In the Supreme Court of the United States

OCTOBER TERM, 1993

DONNA E. SHALALA, SECRETARY OF HEALTH AND HUMAN SERVICES, PETITIONER

v.

GUERNSEY MEMORIAL HOSPITAL

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

DREW S. DAYS, III
Solicitor General

FRANK W. HUNGER
Assistant Attorney General

EDWIN S. KNEEDLER
Deputy Solicitor General

EDWARD C. DUMONT
Assistant to the Solicitor General

ANTHONY J. STEINMEYER
JOHN P. SCHNITKER
Attorneys

Department of Justice
Washington, D.C. 20530
(202) 514-2217

QUESTIONS PRESENTED

1. Whether general Medicare record-keeping and reporting regulations require that provider costs be reimbursed according to "generally accepted accounting principles," despite contrary administrative rules issued by the Secretary of Health and Human Services to govern reimbursement of particular types of costs.

2. Whether, if the regulations do not impose such a requirement, the provision of the Medicare Provider Reimbursement Manual on which the Secretary relied in denying reimbursement in this case is invalid as a legislative rule issued without compliance with the notice-and-comment provisions of the Administrative Procedure Act.

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases:

Cases—Continued: Page

Cases—Continued: Page

Statutes and regulations:

Regulations—Continued: Page

Miscellaneous: Page

In the Supreme Court of the United States

OCTOBER TERM, 1993

No.

DONNA E. SHALALA, SECRETARY OF HEALTH AND HUMAN SERVICES, PETITIONER

v.

GUERNSEY MEMORIAL HOSPITAL

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

The Solicitor General, on behalf of the Secretary of Health and Human Services, respectfully petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Sixth Circuit in this case.

OPINIONS BELOW

The opinion of the court of appeals (App., *infra*, 1a-14a) is reported at 996 F.2d 830. The opinion of the district court (App., *infra*, 15a-37a) is reported at 796 F. Supp. 283. The decision of the Administrator of the Health Care Financing Administration (App., *infra*, 40a-53a) and the decision of the Provider Reimbursement Review Board (App., *infra*, 54a-84a) are unreported.

JURISDICTION

The judgment of the court of appeals was entered on June 18, 1993. A petition for rehearing was denied on October 4, 1993. App., *infra*, 38a-39a. On December 28,

1993, Justice Stevens extended the time for filing a petition for a writ of certiorari to and including February 1, 1994. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATUTORY AND REGULATORY PROVISIONS INVOLVED

1. Section 1861(v)(1)(A) of the Social Security Act, 42 U.S.C. 1395x(v)(1)(A), provides in pertinent part as follows:

> The reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services * * *. In prescribing the regulations referred to in the preceding sentence, the Secretary shall consider, among other things, the principles generally applied by national organizations or established prepayment organizations (which have developed such principles) in computing the amount of payment, to be made by persons other than the recipients of services, to providers of services on account of services furnished to such recipients by such providers. Such regulations may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the use of estimates of costs of particular items or services, may provide for the establishment of limits on the direct or indirect overall incurred costs or incurred costs of specific items or services or groups of items or services to be recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services to individuals

> covered by the insurance programs established under this subchapter, and may provide for the use of charges or a percentage of charges where this method reasonably reflects the costs. * * *

2. The regulations of the Secretary of Health and Human Services implementing 42 U.S.C. 1395x(v)(1)(A), 42 C.F.R. Pt. 413, provide in pertinent part as follows:

> **Subpart B—Accounting Records and Reports**
>
> **§ 413.20 Financial data and reports.**
>
> (a) *General.* The principles of cost reimbursement require that providers maintain sufficient financial records and statistical data for proper determination of costs payable under the program. Standardized definitions, accounting, statistics, and reporting practices that are widely accepted in the hospital and related fields are followed. Changes in these practices and systems will not be required in order to determine costs payable under the principles of reimbursement. Essentially the methods of determining costs payable under Medicare involve making use of data available from the institution's basi[c] accounts, as usually maintained, to arrive at equitable and proper payment for services to beneficiaries.
>
> * * * * *
>
> **§ 413.24 Adequate cost data and cost finding.**
>
> (a) *Principle.* Providers receiving payment on the basis of reimbursable cost must provide adequate cost data. This must be based on their financial and statistical records which must be capable of verification by qualified auditors. The cost data must be based on an approved method of cost finding and on the accrual basis of accounting.
>
> * * * * *
>
> (b) *Definitions*—
>
> * * * * *

(2) *Accrual basis of accounting.* Under the accrual basis of accounting, revenue is reported in the period when it is earned, regardless of when it is collected, and expenses are reported in the period in which they are incurred, regardless of when they are paid.

3. Section 233 of the Secretary's Provider Reimbursement Manual is reprinted at App., *infra*, 85a-89a.

STATEMENT

1. Respondent Guernsey Memorial Hospital is a hospital that provides medical services to eligible Medicare beneficiaries, for which it is reimbursed by the federal government under the Medicare program. See generally 42 U.S.C. 1395c *et seq.* (1988 & Supp. III 1991) (Medicare "Part A"). For the 1985 cost year at issue in this case, providers like respondent were generally reimbursed for capital-related costs on a "reasonable cost" basis.[1]

The Medicare Act defines "reasonable cost" as "the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services" to beneficiaries. 42 U.S.C. 1395x(v)(1)(A). It directs the Secretary of Health and Human Services to promulgate regulations "establishing the method or methods to be used" for determining such costs. *Ibid.* The Secretary's regulations

[1] Since October 1, 1983, hospitals have been reimbursed for general inpatient operating costs under a system of predetermined rates known as the "prospective payment system" or "PPS." See 42 U.S.C. 1395ww(d) (1988 & Supp. III 1991); 42 C.F.R. Pt. 412; *Good Samaritan Hosp.* v. *Shalala*, 113 S. Ct. 2151, 2155 n.3 (1993). Reimbursement for capital-related costs like those involved in this case continued to be made on a "reasonable cost" basis until the beginning of transition to a "capital PPS" system on October 1, 1991. That transition is scheduled to be completed by October 1, 2001. See 42 C.F.R. 412.304.

setting forth general principles of reasonable cost reimbursement are codified at 42 C.F.R. Pt. 413.[2]

In 1972 and 1982, respondent issued bonds to raise money for various capital expenditures.[3] App., *infra*, 3a. The bonds were secured by mortgages on hospital property, bore interest at rates ranging from 5.25% to 12.5%, and were scheduled to have matured in full by 1996 in the case of the 1972 bonds, and by 2012 in the case of the 1982 bonds. See *id.* at 3a, 55a-56a; Admin. Rec. 770, 791. Outstanding bonds from the 1972 and 1982 series cou'd also, at respondent's option, be repaid ("called") beginning in 1984 and 1992, respectively, in exchange for the payment of a "call premium" (prepayment penalty) in addition to the basic principal amount. See App., *infra*, 56a; Admin. Rec. 770, 791.

Both the interest payments on the 1972 and 1982 bonds and the costs associated with their issuance (such as underwriter's discounts and legal and accounting fees) were treated as allowable capital-related costs for purposes of Medicare reimbursement. See, *e.g.*, 42 C.F.R. 413.130(a)(7), (a)(10) and (g); 42 C.F.R. 413.153. Interest costs on the bonds were incurred and reimbursed annually while the bonds remained outstanding. All of respondent's bond issuance costs, by contrast, arose in 1972 and 1982, when the bonds were issued. Such costs

[2] The Medicare "reasonable cost" regulations were originally codified at 20 C.F.R. Pt. 405 (1967). They have been twice redesignated, first at 42 C.F.R. Pt. 405 (1977), see 42 Fed. Reg. 52,826 (1977), and most recently at 42 C.F.R. Pt. 413, see 51 Fed. Reg. 34,790 (1986). Neither redesignation affected the substance of the regulations at issue in this case, and we refer to the regulations as currently codified, giving parallel citations only where they are useful.

[3] The 1972 and 1982 bonds, like the 1985 refunding bonds discussed below, were actually issued on respondent's behalf by the City of Cambridge, Ohio. See App., *infra*, 56a; Admin. Rec. 440-535 (1985 trust indenture); *id.* at 770, 791, 936 (bond prospectuses).

are not recognized in full in the year paid, however, but are generally amortized as part of the provider's costs over the life of the bonds, for both financial accounting and Medicare reimbursement purposes. See App., *infra*, 3a-4a.

In 1985 respondent refinanced the 1972 and 1982 bonds in an "advance refunding" or "defeasance" transaction. In that transaction the bulk of the proceeds of new bonds issued by respondent, together with certain other funds, were transferred into an irrevocable escrow account established under the control of a trustee for the purpose of paying interest on the old bonds while they remained outstanding, and retiring them at a predetermined later date. See App., *infra*, 3a, 16a-17a. Under the terms of the old bonds, establishment and funding of the escrow account released respondent from any further obligation to the holders of those bonds. Aside from eliminating all restrictions imposed under the old bonds (such as mortgage liens and restrictions on additional borrowing), respondent estimated that refinancing with the new bonds, at interest rates varying from 6.5% to 10.5% (depending on the maturity of the individual bonds), would save it approximately $12 million in debt service costs over the remaining life of the two prior bond issues. *Id.* at 3a, 16a, 56a.

Because the amount that respondent was required to pay into the refunding escrow account in order to defease all of its obligations under the 1972 and 1982 bonds exceeded the net amount at which those bonds were carried on respondent's books, respondent realized, at the time of the transaction, an accounting loss equal to that difference.[4] App., *infra*, 44a, 56a-57a. The parties stip-

[4] For these purposes the net carrying amount of the refunded debt consisted of the combined outstanding principal amounts of the 1972 and 1982 bonds, increased by accrued but unpaid interest, and offset by all of the original bond issuance costs that remained unamortized at the time of the refunding transaction. App., *infra*, 57a; see *Early Extinguishment of Debt*, Accounting Principles Board Opinion No. 26, ¶ 3(b) (Accounting Principles Bd. 1972). The difference between that amount and the amount that respondent paid into escrow—that is, the accounting loss recognized on the transaction—reflects not only the unamortized issuance costs, but also a call premium on the 1982 bonds (payable to holders when the bonds were called by the escrow trustee in 1992, but funded in advance by respondent's payment into the escrow account) and the difference between the interest rates payable on the refunded bonds and rates prevailing at the time of the refunding transaction (which affected the amount necessary to fund the escrow account). See App., *infra*, 44a.

ulated that the amount of the loss was $672,581. *Id.* at 17a.

2. a. For financial reporting purposes, respondent reflected the full amount of the refunding loss in 1985, the year of the transaction, in accordance with "generally accepted accounting principles" (GAAP), as set out in *Early Extinguishment of Debt*, Accounting Principles Board Opinion No. 26, ¶ 3(b) (Accounting Principles Bd. 1972) (APB 26).[5] See App., *infra*, 4a. Respondent also included the entire amount of the refunding loss in its Medicare cost report for that year. The "fiscal intermediary" responsible for review of respondent's cost report (see generally 42 C.F.R. 405.1803, 421.100) did not question the calculation of the total refunding loss, but determined that it could not all be claimed in the year of the transaction. That determination relied on a directive contained in the Secretary's Provider Reimbursement Manual (PRM), an extensive set of detailed guidelines issued to assist providers and intermediaries in applying the principles of reimbursement set forth in the Medicare

[5] GAAP standards are set out in official pronouncements of professional organizations such as the former Acounting Principles Board or, since 1978, the Financial Accounting Standards Board; in the absence of an applicable formal standard, what is "generally accepted" depends on "the consensus of the accounting profession." App., *infra*, 4a n.1. See generally D.R. Carmichael, S. Lilien & M. Mellman, *Accountants' Handbook* §§ 2.4(a), 2.5 (7th ed. 1991).

regulations. See 1 & 2 *Medicare & Medicaid Guide* (CCH) ¶¶ 4600-8113 (1993).

Section 233 of the PRM, issued in 1983 and reprinted at App., *infra*, 85a-89a, applies to "advance refunding" transactions like that undertaken by respondent in 1985. Section 233 identifies the individual expense elements of an "advance refunding" transaction and specifies when such expenses are allowable for Medicare reimbursement purposes. It provides, for example, that while incidental expenses (such as legal fees) relating to the refunding transaction itself are allowable as soon as paid or accrued, call premiums are not allowable until the period in which they will be paid to holders of the refunded debt, and unamortized issuance costs of the refunded debt must be amortized over the period from the issuance of the refunding debt to the date that the refunded debt is actually retired. PRM § 233.3(B)(1), (B)(3) and (C); App., *infra*, 86a-87a. The overall approach of Section 233 is "to implicitly recognize any gain or loss incurred as the result of an advance refunding over [the remaining life of the old debt], rather than immediately." PRM § 233.3; App., *infra*, 87a.

b. Respondent appealed to the Provider Reimbursement Review Board (PRRB) (see 42 U.S.C. 1395*oo*(a); 42 C.F.R. 405.1835-405.1873), which reversed the fiscal intermediary's determination. App., *infra*, 54a-84a. Without directly addressing the validity of PRM § 233, the PRRB held that 42 C.F.R. 413.20 and 413.24 (formerly Sections 405.406 and 405.453, respectively) required that the allowance of costs for Medicare reimbursement purposes be determined according to GAAP. App., *infra*, 75a-76a, 82a.

c. The Administrator of the Health Care Financing Administration reversed the PRRB's decision. App., *infra*, 40a-53a; see 42 U.S.C. 1395*oo*(f)(1); 42 C.F.R. 405.1875. While recognizing that "GAAP can be useful in determining costs related to patient care," the Administrator rejected the PRRB's position that the Secretary's regulations required that GAAP be followed in all cases. App., *infra*, 45a-46a. Because under PRM § 233 "Medicare [had] a specific policy in effect governing the treatment of refunding transactions" during the year in question (App., *infra*, 46a), and because that policy recognized that the refunding loss was related to patient care provided in all of the years during which the original bonds remained outstanding (not merely in the year of the refunding transaction) (*id.* at 46a-47a), the Administrator ruled that for Medicare purposes the refunding loss should be treated in accordance with Section 233 of the PRM, rather than in accordance with GAAP.

3. a. The district court upheld the Administrator's determination. App., *infra*, 15a-37a; see 42 U.S.C. 1395*oo*(f)(1); 42 C.F.R. 405.1877. The court concluded that neither the Act nor the Secretary's regulations require adherence to GAAP for Medicare reimbursement purposes. App., *infra*, 31a-32a. In addition, the court held that the Secretary had "a rational basis for concluding that this particular loss should be amortized," and that the departure from GAAP in this case was therefore neither arbitrary nor capricious, because the Secretary's treatment would "more closely approximat[e] the impact of the [refunding] transaction upon the provider's cost of patient care." *Id.* at 32a, 33a.

b. The court of appeals reversed. App., *infra*, 1a-14a. It acknowledged (*id.* at 6a) that the Medicare Act does not require use of GAAP for reimbursement purposes. The court concluded, however, that two of the Secretary's regulations, 42 C.F.R. 413.20 and 413.24—which state that "[s]tandardized * * * accounting * * * and reporting practices * * * are followed" for Medicare purposes; that "[c]hanges in these practices and systems will not be required in order to determine" allowable costs; and that "cost data must be based on * * * the accrual basis of accounting"—effectively required that the Secretary

determine allowable costs in accordance with GAAP. *Id.* at 6a-7a. The court rejected the Secretary's construction of the quoted regulations: that they address only the manner in which providers must report their costs, and not the manner in which costs are to be reimbursed. *Id.* at 11a-13a.

The court recognized that there was "nothing irrational" about the non-GAAP treatment of advance refunding costs required by Section 233 of the PRM, and it had "no doubt" that the Secretary would have the authority under the Medicare Act to adopt it. App., *infra*, 8a-9a. But because it had interpreted the Secretary's more general regulations to require adherence to GAAP, the court held that to follow Section 233 of the PRM would "wor[k] a substantive change in existing regulations" and "impermissibly chang[e]" their meaning. App., *infra*, 9a, 10a. The court therefore viewed Section 233 as a "legislative" rather than an "interpretative" rule (*id.* at 9a), and held it "void by reason of the agency's failure to comply with the Administrative Procedure Act in adopting it" (*id.* at 3a). The court accordingly remanded the case for entry of summary judgment against the Secretary on the advance refunding issue.[6]

[6] Both the district court (App., *infra*, 34a-37a) and the court of appeals (*id.* at 14a) also addressed a separate issue involving the treatment of interest earned by respondent on an account set up to accumulate funds for the payment of interest on the 1985 refunding bonds. Both courts ruled in favor of the Secretary on that question, and it is not at issue in this petition.

REASONS FOR GRANTING THE PETITION

The court of appeals erred in holding that in the absence of specific regulatory authority to the contrary, the Secretary's general Medicare record-keeping regulations require allowance, in a particular cost period, of all otherwise proper costs allocated to that period under "generally accepted accounting principles" (GAAP). Those principles are developed outside the Medicare context and outside the Department of Health and Human Services, and therefore cannot control the Secretary's exercise of discretion in administering the Medicare program.

The court of appeals' conclusion—that the Secretary has effectively delegated to the accounting profession her ultimate authority to determine the amount of reimbursement due a hospital under the Medicare program—conflicts with the decisions of at least two other courts of appeals. The question whether the Secretary and fiscal intermediaries are required to follow GAAP is also of substantial practical importance, for two reasons. First, its potential financial impact on the Medicare program is substantial. Second, there are serious and disruptive implications to the court of appeals' approach of interpreting broad and ambiguous statements of general regulatory policy to invalidate specific and sensible interpretative rules, designed to guide providers and Medicare administrators in their implementation of a large and complex governmental health benefits program. The decision therefore merits review by this Court.

1. The court of appeals' holding rests on its conclusion that two of the Secretary's general Medicare reimbursement regulations, 42 C.F.R. 413.20 and 413.24, mandate the use of GAAP to determine allowable costs, unless the Secretary has promulgated a more specific regulation dealing with a particular cost issue. App., *infra*, 6a-13a. That issue has divided the courts of appeals.

Decisions from two circuits arguably support the position taken by the Sixth Circuit in this case. In *Villa View*

Community Hosp., Inc. v. *Heckler*, 720 F.2d 1086, 1093 n.18 (1983), the Ninth Circuit stated that GAAP must control Medicare cost determinations in the absence of a contrary regulation, and applied that principle after concluding that regulations cited by the Secretary were inapplicable on the facts of the case. See also *National Medical Enterprises* v. *Bowen*, 851 F.2d 291, 294 (9th Cir. 1988) (rejecting Secretary's non-GAAP calculation of return on equity in the absence of a specific regulation); cf. *HCA Health Services of Midwest, Inc.* v. *Bowen*, 869 F.2d 1179, 1182 (9th Cir. 1989) (quoting *Villa View*).

In *Charlotte Memorial Hosp. & Medical Ctr., Inc.* v. *Bowen*, 860 F.2d 595, 598-599 (1988), the Fourth Circuit also noted the existence of conflicting positions on the issue of mandatory use of GAAP for purposes of Medicare reimbursement. While reserving final judgment on the question (*id.* at 600), it expressed the view that the Secretary would be "at the very limit of [her] authority" in prescribing accounting treatments that conflicted with GAAP, and in any event could not do so without showing that GAAP treatment would not "accurately reflect the cost of patient care." *Ibid.* (quoting *Villa View*, 720 F.2d at 1093 n.18).[7]

Other courts, by contrast, have held that the Secretary's general reimbursement regulations (including Sec-

[7] The *Charlotte* court rejected the Secretary's non-GAAP treatment of certain deferred compensation amounts, after it concluded that the GAAP approach did accurately reflect the provider's cost of care. 860 F.2d at 601. A number of district courts have also accepted the mandatory-GAAP argument in the specific context of advance refunding transactions. See *Methodist-Evangelical Hosp., Inc.* v. *Shalala*, No. 92-2887-LFO (D.D.C. Dec. 22, 1993); *Graham Hosp. Ass'n* v. *Sullivan*, 832 F. Supp. 1235, 1242-1244 (C.D. Ill. 1993), appeals pending, Nos. 94-1098 & 94-1099 (7th Cir.); *Baptist Hosp. East* v. *Sullivan*, 767 F. Supp. 139, 141 (W.D. Ky. 1991); *Ravenswood Hosp. Medical Ctr.* v. *Schweiker*, 622 F. Supp. 338, 344-345 (N.D. Ill. 1985); *Mercy Hosp.* v. *Sullivan*, [1992-2 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 40,227, at 30,602-30,603 (D. Me. 1991).

tions 413.20 and 413.24) do not require the Secretary to apply GAAP in determining what costs are allowable under Medicare in a given reporting period. In *Sun Towers, Inc.* v. *Heckler*, 725 F.2d 315, cert. denied, 469 U.S. 823 (1984), for example, the Fifth Circuit upheld the Secretary's non-GAAP treatment of certain "stock maintenance" costs, observing that what is now Section 413.20 "is directed at the type of financial data and reports required of providers," and "is not a regulation affecting the substantive provisions of the program as to what constitutes reimbursable costs." 725 F.2d at 328-329 (quoting *American Medical Int'l, Inc.* v. *Secretary of HEW*, 466 F. Supp. 605, 623-624 (D.D.C. 1979), aff'd on other grounds, 677 F.2d 118 (D.C. Cir. 1981)). Similarly, in *Methodist Hosp. of Indiana, Inc.* v. *United States*, 626 F.2d 823, 826-827 (Ct. Cl. 1980), the court upheld the Secretary's refusal to allow certain pension costs, holding that "[n]either th[e] statute nor the regulations requir[e] that the Secretary find that a cost is reasonable and actually incurred simply because it is an accrued liability for accounting purposes."[8] The court of appeals for the District of Columbia Circuit has expressed the same view, albeit in dictum. See *Richey Manor, Inc.* v. *Schweiker*, 684 F.2d 130, 135 (1982) (Bork, J.).

Finally, the Ninth Circuit has also rendered decisions (both before and after those, cited above, that are consistent with the decision below) that support the Secretary's position on the application of GAAP accounting. See *North Clackamas Community Hosp.* v. *Harris*, 664 F.2d 701, 706 (1980) (Kennedy, J.) (mis-cited in *Villa*

[8] See also *Mother Frances Hosp.* v. *Shalala*, 818 F. Supp. 990, 994-995 (E.D. Tex. 1993) (advance refunding), appeal pending, No. 93-4388 (5th Cir.) (argued Jan. 31, 1994); *Queen's Medical Ctr.* v. *Sullivan*, 797 F. Supp. 821, 824-826 (D. Haw. 1991) (noting conflict in Ninth Circuit decisions and construing both regulations in favor of Secretary); *American Medical Int'l, Inc.* v. *Secretary of HEW*, 466 F. Supp. at 623-624.

View, supra); *National Medical Enterprises, Inc.* v. *Sullivan*, 916 F.2d 542, 547 (1990) ("[GAAP] procedures promote uniform recordkeeping; they do not prescribe reimbursable costs"), cert. denied, 111 S. Ct. 2014 (1991). While such an intra-circuit conflict is not in itself a ground for further review, along with the conflict among the other courts of appeals it serves to demonstrate the confusion that has arisen in the lower courts over the question presented. That widespread confusion merits resolution by this Court.[9]

2. The court of appeals erred in concluding that the Secretary is required to apply GAAP in adjudicating Medicare reimbursement claims, in the absence of a specific regulation to the contrary.

a. The court of appeals acknowledged that the Medicare Act itself imposes no such requirement. App., *infra*, 6a. Indeed, the Act explicitly delegates to the Secretary the authority and responsibility to "establis[h] the method

[9] There is not yet a conflict among the courts of appeals regarding mandatory application of GAAP in the precise context of advance refunding transactions, although the issue is presented in that context in cases that are now pending in the Fifth Circuit, *Mother Frances Hosp.* v. *Shalala* (see note 8, *supra*), and Seventh Circuit, *Graham Hosp. Ass'n* v. *Sullivan (Shalala)* (see note 7, *supra*). The Fifth Circuit has already sustained the Secretary's position on the GAAP issue in *Sun Towers, Inc.* v. *Heckler*, *supra*, and presumably will adhere to that position in *Mother Frances*. In any event, the advance refunding cases turn on the broader issue of whether the Secretary's general regulations require application of GAPP in all contexts not covered by a specific regulation. There is accordingly no reason to await developments in the advance refunding cases in other courts of appeals. That is especially so because if review is denied in this case, the Sixth Circuit's decision will require resolution against the government of a similar case, involving a group of almost 30 hospitals, now pending in that court. *St. John Hospital* v. *Shalala*, No. 93-2334 (briefing stayed pending filing of the government's petition for a writ of certiorari in this case). The significant amount of money at issue in *St. John* will be irretrievably lost if review is deferred to await the development of a more specific conflict.

or methods to be used, and the items to be included, in determining [allowable] costs," and provides that in establishing those methods the Secretary

> may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the use of estimates of costs of particular items or services, may provide for the establishment of limits on * * * costs * * *, and may provide for the use of charges or a percentage of charges where this method reasonably reflects * * * costs.

42 U.S.C. 1395x(v)(1)(A). Given that broad and flexible mandate to the Secretary, it is exceedingly unlikely that the Secretary would have intended, in general regulations promulgated as part of the initial implementation of the Medicare statute, to abdicate to the accounting profession (or to anyone else) the ultimate responsibility for making particular cost reimbursement determinations. The court of appeals' contrary interpretation of the regulations now codified at 42 C.F.R. 413.20 and 413.24 is implausible for that reason alone.

The court of appeals remarked on the fact that the Act requires the Secretary, in prescribing cost-determination regulations, to "consider * * * the principles generally applied by national organizations." App., *infra*, 6a (quoting 42 U.S.C. 1395x(v)(1)(A)). The court read that provision as directing the Secretary to consider such organizations' general *financial accounting* principles, and specifically GAAP (which the court felt that it could "safely assume" such "national organizations" would apply). App., *infra*, 6a. The court, however, elided the remainder of the statutory phrase: "or established prepayment organizations (which have developed such principles) in computing the amount of payment, to be made by persons other than the recipients of services, to pro-

viders of services on account of services furnished to such recipients by such providers." In context, the statutory language plainly refers to the *reimbursement* principles developed by national insurance or prepayment organizations in the health services sector (although those principles would, of course, have a significant cost accounting component).

During hearings on the original Medicare legislation, Social Security Commissioner Ball stated that his agency would generally "expect to follow" the "principles of payment for hospital care" set forth in a 17-page pamphlet produced by the American Hospital Association (AHA). *Medical Care for the Aged: Executive Hearings Before the House Comm. on Ways and Means*, 89th Cong., 1st Sess. Pt. 1, at 142 (1965). Later, in proposing the first set of Medicare regulations, Commissioner Ball reported that, in conformity with the statutory provision quoted by the court of appeals, he had consulted with representatives of the AHA and similar groups. 31 Fed. Reg. 7864 (1966); see also *Reimbursement Guidelines for Medicare: Hearing Before the Senate Comm. on Finance*, 89th Cong., 2d Sess. 45, 59, 61-63, 197-198 (1966); *1st Annual Report on Medicare*, H.R. Doc. No. 331, 90th Cong., 2d Sess. 39-40 (1968). Neither the AHA pamphlet, nor either of the two subsidiary publications on which it relies, refers to GAAP as a guiding principle of hospital reimbursement. See American Hospital Ass'n, *Principles of Payment for Hospital Care* (rev. Aug. 1963);[10] AHA,

[10] The pamphlet states (at 6) that "[t]he determination of reimbursable cost requires acceptance and use of uniform definitions, accounting, statistics, and reporting"—a general principle similar to that eventually adopted by the Secretary in what is now 42 C.F.R. 413.20. As the pamphlet's explanatory comment goes on to state (at 6-7), however, "[h]ospitals must agree to provide the *basic information* necessary for *comparable analysis* of cost and equitable distribution of payments for third-party purchasers. * * * Only through uniformity of records and reports can third-party agencies be assured that they are paying for similar services in

Uniform Chart of Accounts and Definitions for Hospitals (1959); AHA, *Cost Finding for Hospitals* (1957). The available evidence thus confirms what is in any event the natural reading of the statutory language: that the "principles * * * applied by national organizations or established prepayment organizations" that the statute requires the Secretary to "consider" have nothing specifically to do with GAAP.

b. The language of the regulations relied on by the court below (App., *infra*, 6a-8a) provides no more support for its holding. The more detailed of those regulations, 42 C.F.R. 413.24(a) (originally codified at 20 C.F.R. 405.453(a) (1967) and reprinted at page 3, *supra*) specifies only that most providers must support their claims for Medicare reimbursement with "adequate cost data" based on "an approved method of cost finding and on the accrual basis of accounting." 42 C.F.R. 413.24(a). The court of appeals evidently read the requirement that cost data be reported "on the accrual basis of accounting"—rather than on the basis of cash receipts and disbursements—to entail automatic imposition, in every detail, of the *particular version* of accrual accounting embodied in GAAP. App., *infra*, 7a-8a.

The court's interpretation would be strained even if the regulation itself provided no definition of its terms. In fact, however, Section 413.24(b)(2) does provide a specific definition:

> *Accrual basis of accounting.* Under the accrual basis of accounting, revenue is reported in the period when it is earned, regardless of when it is collected, and expenses are reported in the period in which they are incurred, regardless of when they are paid.

different hospitals on comparable bases." (Emphasis added). As with the regulatory language discussed below, those statements are directed toward the "uniformity of records and reports" required of providers, not toward whether particular costs are appropriate for reimbursement in particular periods.

That definition nowhere mentions GAAP, the Accounting Principles Board, or any other specific source of accounting authority, which could have been easily referenced had the regulation's drafters intended to incorporate it into the general requirement of accrual accounting.[11] In any event, Section 413.24 speaks only to the manner in which information must be "reported" in a provider's books, and not to the manner in which the data derived from those books will be analyzed by the Secretary (or a fiscal intermediary acting on her behalf) in determining which costs are allowable under Medicare in any given period.

The more general provisions of 42 C.F.R. 413.20(a) (reprinted at page 3, *supra*) provide equally little support for the court's analysis, although their purpose and effect are more ambiguous. Originally placed at the end of a series of essentially prefatory sections of the initial Medicare regulations, see 20 C.F.R. 405.406 (1967), Section 413.20(a) provides:

[11] The text of APB 26 itself establishes that the amortization of advance refunding costs required by PRM § 233 (see App., *infra*, 85a-89a) is consistent with any general requirement to use "accrual accounting." APB 26 adopted as part of GAAP the immediate-recognition treatment used by respondent in this case. The opinion makes clear, however, that before its issuance a considerable body of professional opinion supported the amortization treatment embodied in Section 233 as the correct "accrual accounting" treatment for all or most debt-for-debt refundings. See APB 26, ¶¶ 5-6, 10. Indeed, one APB member who concurred in the opinion (and two of the dissenters) specifically disagreed with its requirement of immediate recognition in the case of debt refundings like that at issue here. See *id.* (statement of individual views). See also *Accounting and Financial Reporting for Refundings of Debt Reported by Proprietary Activities*, Statement of Governmental Accounting Standards No. 23 (Gov't Accounting Standards Bd. 1993) (adopting amortization method of accounting for refunding losses reported by proprietary activities—including hospitals—operated by state and local governments).

> The principles of cost reimbursement require that providers maintain sufficient financial records and statistical data for proper determination of costs payable under the program. Standardized definitions, accounting, statistics, and reporting practices that are widely accepted in the hospital and related fields are followed. Changes in these practices and systems will not be required in order to determine costs payable under the principles of reimbursement. Essentially the methods of determining costs payable under Medicare involve making use of data available from the institution's basi[c] accounts, as usually maintained, to arrive at equitable and proper payment for services to beneficiaries.

Because of its broad terms and its placement in the original set of regulations, it is unlikely that Section 413.20(a) was ever intended to do more than provide general reassurance to providers contemplating participation in the Medicare program, and to alert a reader to the record-keeping and cost accounting requirements set out in more detail in what later became Section 413.24.[12]

In any event, Section 413.20(a) by its terms does not require use of GAAP. It refers only to practices standard "in the hospital and related fields," suggesting if anything the use of "specially" rather than "generally" accepted principles. And of particular relevance here, Section 413.20(a) states that the methods for determining allowable costs under Medicare "involve *making use of data available* from the [provider's] basi[c] accounts, as usually maintained, to arrive at" proper reimbursement—not that those methods involve accepting the provider's final cost accounting figures (whether GAAP-based or otherwise)

[12] The original regulations included both an introductory and a later, more specific section to cover each of several major points. Those sections were generally relocated adjacent to each other in the 1986 recodification (see note 2, *supra*). Compare the correspondence between original Sections 405.406 and 405.453 (now 413.20 and 413.24); 405.405 and 405.454 (now 413.60 and 413.64); 405.403-

without further adjustment in light of the purposes and requirements of the Medicare program. As in the case of Section 413.24, the regulation is directed toward ensuring the existence of provider records sufficient to enable the Secretary and fiscal intermediaries to calculate the costs allowable under Medicare, not toward prescribing how that calculation will be made. Compare, *e.g.*, 42 C.F.R. 413.53 (specifying detailed rules for apportionment of costs between Medicare and non-Medicare patients); 42 C.F.R. 413.134-413.149 (specifying allowable depreciation costs).

At most, Section 413.20(a) is ambiguous with respect to the imposition of any requirement that a provider's books conform to GAAP—let alone that figures recorded in accordance with GAAP be accepted, without further justification, as representing costs that were properly incurred in a given period for purposes of reimbursement under Medicare. Even granting that doubtful ambiguity, however, the Secretary's longstanding interpretation of her own regulations is certainly neither "plainly erroneous" nor "inconsistent with the regulation[s]," and it is therefore entitled to "controlling weight." *Stinson* v. *United States*, 113 S. Ct. 1913, 1919 (1993) (quoting *Bowles* v. *Seminole Rock & Sand Co.*, 325 U.S. 410, 414 (1945)); see also *Martin* v. *OSHRC*, 499 U.S. 144, 150-151 (1991). The court of appeals erred in failing to respect that fundamental proposition.

c. The Secretary's position that GAAP does not control the appropriate treatment of particular costs for reimbursement purposes is sound not only in general, but also in the particular context involved in this case. It is a central concern of "reasonable cost" reimbursement under Medicare that any costs allowed should be properly matched to services provided to the program's beneficiaries. That

---

405.404 and 405.452 (now 413.50 and 413.53 (Section 405.404 has no current counterpart)); and 405.402 and 405.451 (now 413.5 and 413.9).

principle alone makes it important to allocate costs that relate to more than one accounting period (like most capital costs among the periods when the corresponding benefits will be realized. See, *e.g.*, 42 C.F.R. 413.130(c) (amortization of cost of capital improvements); 42 C.F.R. 413.134-413.144 (depreciation of capital assets).

Proper periodic allocation is all the more necessary because allowable non-specific costs are apportioned to Medicare in each accounting period based, in general, on some measure of the overall use of hospital facilities by Medicare (as distinguished from non-Medicare) patients. See generally 42 C.F.R. 413.50-413.56. Thus, shifting costs among reporting years can significantly affect the costs appropriately borne by Medicare—if, for example, a provider's Medicare utilization rates fluctuate significantly from period to period, or if the provider chooses to withdraw from the program entirely before all benefits of some previously incurred cost have been realized. Proper periodic allocation also helps to ensure compliance with the statutory and regulatory prohibition against "cross-subsidization" between Medicare and non-Medicare patients. See 42 U.S.C. 1395x(v)(1)(A)(i); 42 C.F.R. 413.5(a), 413.9.

In the context of the Medicare program, it is the responsibility of the Secretary to determine how legitimate costs that generate long-term benefits should be allocated among reporting periods. The discussion of various possible approaches—including the alternative reflected in PRM § 233—in the text of APB 26 itself (see APB 26, ¶¶ 5-7) demonstrates that the Secretary may reasonably conclude that the advance refunding loss recognized by respondent for financial reporting purposes in 1985 in fact represented costs associated with providing health care services throughout the life of the old financing arrangement, and should therefore be amortized over the remaining term of the old bonds for purposes of Medicare reimbursement. Indeed, the court of appeals acknowledged that the Secretary could properly follow that ap-

proach. App., *infra*, 8a-9a. The court ruled in respondent's favor on the sole ground that the Secretary's reasonable treatment of the particular costs at issue here was precluded by what the court believed to be a regulatory requirement that she observe instead the alternative treatment selected by the Accounting Principles Board.[13] Because, as discussed above, the court erred in discerning any such regulatory requirement, the Secretary's concededly rational treatment should prevail.

3. The court's basic error in interpreting the Secretary's regulations also gave rise to its equally erroneous conclusion (App., *infra*, 3a) that Section 233 of the PRM "effects a substantive change in the regulations" and is therefore a "substantive" rule that is "void by reason of the agency's failure to comply with the Administrative Procedure Act in adopting it." As we read the court's opinion, that conclusion has no force independent of the court's determination that the Manual provision, which was issued without notice or comment, conflicts with a GAAP accounting requirement embodied in Sections 413.20 and 413.24 of the regulations; in the absence of any such conflict, the court of appeals would presumably have recognized Section 233 as a valid elaboration of the regulations' other provisions concerning the determination of reasonable costs. Nonetheless, in the event that the court's APA conclusion might instead be read as an independent holding (rendered without the benefit of brief-

[13] APB 26 makes clear that the Board's selection of the immediate-recognition alternative was largely the result of striving for consistency between debt-for-debt refundings like respondent's and other early retirements of debt. See APB 26, ¶¶ 16-19. The decision of course gave no consideration at all to the particular context of a government (or other third-party) health care cost reimbursement program. This Court has previously recognized, in the tax context, that standard financial accounting practices may not adequately serve legitimate governmental objectives. *Thor Power Tool Co.* v. *Commissioner*, 439 U.S. 522, 542 (1979). Compare also GASB Statement No. 23 (cited at note 11, *supra*).

ing by the parties), we have included it in the questions presented and address it briefly here.

Under the Administrative Procedure Act (APA), substantive or "legislative" rules may not be issued without prior notice and the opportunity for public comment. 5 U.S.C. 553(b) and (c). The APA, however, explicitly exempts from its notice-and-comment requirements various kinds of lesser administrative action, including the issuance of "interpretative rules" and "statements of policy." 5 U.S.C. 553(b); see, *e.g.*, *Lincoln* v. *Vigil*, 113 S. Ct. 2024, 2033 (1993).

Courts have recognized that the categories of "interpretative" as opposed to "substantive" rules "have 'fuzzy perimeters' and establish 'no general formula.' " *Batterton* v. *Marshall*, 648 F.2d 694, 702 (D.C. Cir. 1980) (footnote omitted). To make the distinction, the courts have asked whether the rule "impos[es] a new substantive obligation," *McCown* v. *Secretary of HHS*, 796 F.2d 151, 157 (6th Cir. 1986), cert. denied, 479 U.S. 1037 (1987), or creates "new law, rights or duties." *Friedrich* v. *Secretary of HHS*, 894 F.2d 829, 834 (6th Cir.), cert. denied, 498 U.S. 817 (1990) (quoting *General Motors Corp.* v. *Ruckelshaus*, 742 F.2d 1561, 1565 (D.C. Cir. 1984) (en banc), cert. denied, 471 U.S. 1074 (1985)). If so, it is substantive. See *Alcaraz* v. *Block*, 746 F.2d 593, 613 (9th Cir. 1984). Interpretative rules, on the other hand, "merely clarify or explain existing law or regulations." *Seldovia Native Ass'n* v. *Lujan*, 904 F.2d 1335, 1347 (9th Cir. 1990). "[I]nterpretative rules are statements as to what the administrative officer thinks the statute or regulation means" when applied in particular situations. *Gibson Wine Co.* v. *Snyder*, 194 F.2d 329, 331 (D.C. Cir. 1952).

Applying these standards, and on the assumption that Sections 413.20 and 413.24 do not require adherence to GAAP for purposes of Medicare reimbursement, Section 233 of the PRM is plainly an interpretative rule. The Secretary's regulations authorize reimbursement of "capi-

tal-related costs" that are "appropriate and helpful in * * * maintaining the operation of patient care facilities." 42 C.F.R. 413.9(b)(2); see generally 42 C.F.R. 413.130-413.157. Such costs include "[n]ecessary and proper interest" and other costs associated with capital indebtedness. See 42 C.F.R. 413.130(a)(7) and (g); 42 C.F.R. 413.153(a)(1) and (b). The regulations also require that allowable costs be related to beneficiary care. 42 C.F.R. 413.5(a), 413.9; see 42 U.S.C. 1395x(v)(1)(A)(i).

The regulations do not, however, spell out how otherwise allowable bond issuance costs, which are normally amortized over the life of the bonds to which they relate, should be treated when the liability to which they relate is removed from the provider's books by an advance refunding transaction. Nor do they make clear how other costs of such a refunding should be allocated among reporting periods to maintain a proper relationship to the provision of beneficiary care. The Provider Reimbursement Manual exists to provide detailed interpretative guidance in exactly such situations (see 42 C.F.R. 405.1803(b), 405.1829(a), 405.1867), and Section 233 provides the specific answer applicable here. Section 233 "merely * * * elaborate[s] on what is already contained in the regulations," *Homan & Crimen, Inc.* v. *Harris*, 626 F.2d 1201, 1210 (5th Cir. 1980); it neither imposes new substantive obligations nor creates "new law, rights or duties." *General Motors Corp.* v. *Ruckelshaus*, 742 F.2d at 1565. In the absence of an overriding regulatory requirement of GAAP-based treatment, there is no warrant for the court of appeals' conclusion that PRM § 233 is void as an improperly issued substantive or "legislative" rule.

4. The court of appeals' erroneous interpretation of the complex statutory and regulatory scheme governing the Medicare program warrants review by this Court. As explained above, the courts of appeals are divided on the question whether the Secretary and intermediaries acting on her behalf are required to apply GAAP when adjudicating Medicare reimbursement claims.

Moreover, the issue is of substantial practical importance. The Department of Health and Human Services informs us that there are at least 70 cases (involving 126 providers) pending before the agency or in court that raise the GAAP-requirement issue in the specific context of advance refunding transactions. The agency expects more such cases (and other cases raising the GAAP issue in contexts other than advance refunding) to arise in future years—and, in particular, before completion of the processing of cost reports for the 1990 fiscal year, after which most providers will be reimbursed for capital costs under the prospective payment system (see note 1, *supra*).[14]

The Department of Health and Human Services estimates the total amount of refunding losses at issue in pending cases to be approximately $240 million. In most cases, the amount of the allowable refunding loss is undisputed, and the only issue is whether the loss should be allowed in the year of the refunding transaction or amortized over some longer period. In such cases, the fiscal impact on the Medicare program consists primarily

[14] The issue is of continuing importance despite the ongoing transition to PPS reimbursement of capital-related costs. See note 1, *supra*; compare *Good Samaritan Hosp.* v. *Shalala*, 113 S. Ct. at 2155 n.3, 2157. First, certain Medicare providers (or some of their facilities) will continue to be reimbursed under the "reasonable cost" system. See 42 C.F.R. 412.22-412.30, 412.300(b). *Good Samaritan*, 113 S. Ct. at 2155 n.3. Second, during the ten-year capital PPS transition period commencing October 1, 1991 (see 42 C.F.R. 412.304), a portion of a provider's reimbursement for capital-related costs under PPS will generally be based on its historic costs during a base year—usually fiscal 1990. If the Secretary were required to recognize advance refunding losses in their entirety in the year of a refunding transaction, a provider that recognized such a loss in what became its base year could receive a substantial windfall, the effects of which would continue throughout the PPS transition period.

of the time value of making payments on an accelerated basis.[15] The Department estimates that the amount thus at issue in all pending cases presenting the GAAP issue in the advance refunding context alone could be up to $50 million in substantive liability and $50 million in statutory pre-judgment interest (see 42 U.S.C. 1395*oo*(f)(2)).

Finally, even aside from its potential monetary impact on the Medicare program, the court of appeals' decision disregards this Court's repeated injunction that an agency's interpretation of its own regulations should be given "controlling weight" unless it is plainly erroneous or inconsistent with the language of the regulation. *E.g.*, *Stinson*, 113 S. Ct. at 1919 (collecting cases). Scrupulous observance of that principle is particularly important in the context of Medicare's complex statutory and regulatory regime. In administering that regime in a changing medical and financial world, the Secretary must rely not only on the general principles of the Medicare statute and regulations, but also on an extensive set of detailed interpretative guidelines such as those set out in the PRM. Moreover, while judicial misinterpretation of the Secretary's regulations could in theory be corrected through further agency action, such action could not be made retroactive to the numerous cases already pending before the

[15] As explained above (see page 21, *supra*), "reasonable cost" reimbursements are determined by apportioning a provider's total allowable costs for a given period between Medicare and non-Medicare patients. See 42 C.F.R. 413.50-413.56. Thus, for example, out of a total advance refunding loss of $672,581, respondent sought reimbursement of approximately $314,000, based on its Medicare utilization rate for 1985. The percentage of a provider's allowable costs properly apportionable to Medicare patients may vary substantially from period to period. Thus, spreading recognition of a provider's accounting loss over several years for Medicare purposes will affect not only the time value of the reimbursement, but potentially also the total amount finally apportionable to Medicare patients and reimbursable by the government. See, *e.g.*, App., *infra*, 49a & n.13 (Administrator's decision).

agency or in the courts—or, indeed, to any dispute that might arise over a cost report for any year preceding issuance of a new regulation. See *Bowen* v. *Georgetown Univ. Hosp.*, 488 U.S. 204 (1988).

The court of appeals' use of innocuous or, at most, ambiguous statements contained in the first general regulations issued under the Medicare Act to invalidate otherwise valid, specific and sensible interpretative rules, adopted after years of practical experience and set out in the Provider Reimbursement Manual, threatens to disrupt both the administration of the Medicare program and the proper relationship between the Secretary and the courts. Its decision warrants review and reversal by this Court.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted.

DREW S. DAYS, III
Solicitor General

FRANK W. HUNGER
Assistant Attorney General

EDWIN S. KNEEDLER
Deputy Solicitor General

EDWARD C. DUMONT
Assistant to the Solicitor General

ANTHONY J. STEINMEYER
JOHN P. SCHNITKER
Attorneys

FEBRUARY 1994

APPENDIX A

UNITED STATES COURT OF APPEALS
SIXTH CIRCUIT

No. 92-3563

GUERNSEY MEMORIAL HOSPITAL,
PLAINTIFF-APPELLANT,

v.

SECRETARY OF HEALTH AND HUMAN SERVICES,
DEFENDANT-APPELLEE.

Argued March 2, 1993

Decided June 18, 1993

Before: JONES and NELSON, Circuit Judges; and LIVELY, Senior Circuit Judge.

DAVID A. NELSON, Circuit Judge.

Appellant Guernsey Memorial Hospital, a participant in the federal government's Medicare program, is entitled to reimbursement by the Department of Health and Human Services for reasonable costs incurred in providing services to Medicare patients. Such costs include the cost of money employed in financing hospital improvements.

The particular costs at issue in this case are known technically as "advance refunding" or "defeasance" costs: costs incurred in connection with the refunding of bonded mortgage indebtedness ahead of schedule in order to obtain new financing. It is undisputed that the hospital is entitled to reimbursement for reasonable advance refunding costs. There is a dispute, however, as to when and how reimbursement is to be made—in a lump sum payable now, or in a series of payments stretched over the remaining life of the original bonds?

Under generally accepted accounting principles (referred to in the accounting world as "GAAP"), advance refunding costs are not amortized over the life of the original bonds. Such costs must be recognized, in full, up front. Regulations promulgated by the Department strongly imply, if they do not say in so many words, that reimbursement will be made on the basis indicated by GAAP.

A Department manual on reimbursement provides otherwise. The manual says that any loss incurred through advance refunding of existing debt must be amortized, as opposed to being recognized immediately.

Unlike the regulation, the manual was not adopted in accordance with the notice and comment procedures mandated, for substantive rules, by the rulemaking section of the Administrative Procedure Act, 5 U.S.C. § 553. The dispositive question presented here is whether the manual provision constitutes a substantive rule, under the Administrative Procedure Act, or an "interpretative" rule to which the statutory notice and comment requirements do not apply. If substantive, the rule is void; if merely interpretive, it is not. See *State of Ohio Dep't of Human Services v. U.S. Dep't of Health & Human Services*, 862 F.2d 1228 (6th Cir. 1988).

We conclude that the manual's amortization requirement effects a substantive change in the regulations. It is not an interpretation, it is a stand-alone substantive rule. And it is void by reason of the agency's failure to comply with the Administrative Procedure Act in adopting it.

The district court, in the decision now before us on appeal, impliedly held the manual to be interpretive; the court therefore upheld the validity of the amortization requirement. 796 F.Supp. 283. We shall reverse the court's decision on this point. The decision will be affirmed on an unrelated point involving the proper treatment of income earned on funds placed in an account dedicated to the payment of interest on the newly issued bonds.

I.

Guernsey Memorial Hospital, a not-for-profit acute care institution located in Cambridge, Ohio, paid for certain capital improvements with the proceeds of mortgage revenue bonds issued in 1972 and 1982. This bonded indebtedness was refinanced, on advantageous terms, in 1985.

Most of the proceeds of the 1985 bond issue were used to purchase United States Treasury obligations that were escrowed for the benefit of the holders of the older bonds. This advance refunding arrangement permitted defeasance of the mortgages on the hospital property, and the liens of the 1972 and 1982 bond indentures were discharged and released in 1985.

Prior to the 1985 advance refunding the hospital had been amortizing various costs (including legal

and accounting fees, feasibility study costs, and underwriter discounts) incurred in connection with the earlier bond issues. When the earlier bonds were "defeased," the hospital—acting in accordance with GAAP,[1] as required by 42 C.F.R. § 413.20—took the unamortized balance of these costs as a charge against current income. A call premium advanced by the hospital in 1985 as part of the cost of defeasance was handled the same way, also in accordance with the requirements of GAAP.

The advance refunding costs came to a net amount of $672,581. Of that sum, the hospital sought reimbursement of approximately $314,000.

The request for reimbursement was denied by the "fiscal intermediary" to which such requests are routed initially. The hospital appealed to the Provider Reimbursement Review Board, a body established by the Secretary of HHS pursuant to 42 U.S.C. § 1395*oo*. After an evidentary hearing the Review Board issued a decision allowing reimbursement in full as of 1985. (The Review Board also decided in

[1] GAAP consists of the three official publications of the American Institute of Certified Public Accountants: Accounting Principles Board opinions, Financial Accounting Standards Board statements, and Accounting Research Bulletins. If these publications are silent on a question, the consensus of the accounting profession governs. See *HCA Health Services of Midwest, Inc. v. Bowen*, 869 F.2d 1179, 1181 n. 3 (9th Cir.1989). The Accounting Principles Board issued APB Opinion 26, titled "Early Extinguishment of Debt," in 1972. The opinion directed that "[a] difference between the reacquisition price and the net carrying amount of the extinguished debt should be recognized currently in income of the period of extinguishment as losses or gains and identified as a separate item. . . . Gains and losses should not be amortized to future periods." Opinion 26, ¶ 20.

favor of the hospital on a debt service fund issue that will be discussed in Part III of this opinion.) Upon review by the Administrator of the Health Care Financing Administration, however, the decision of the Review Board was reversed. Under 42 C.F.R. § 405.1875 the reversal represented the final decision of the Secretary.

Insofar as reimbursement of advance refunding costs was concerned, the Administrator held, in accordance with a policy announced in § 233 of the agency's Provider Reimbursement Manual, that the items in question had to be amortized over the life of the refunded debt. The Administrator said that the manual section was "interpretive" of the regulations.

Pursuant to § 1878(f) of the Social Security Act, 42 U.S.C. § 1395*oo*(f), the hospital sought judicial review in the United States District Court for the Southern District of Ohio. In a carefully considered decision published at 796 F.Supp. 283 (S.D.Ohio 1992), that court denied a summary judgment motion of the hospital and granted summary judgment to the Secretary on both the amortization issue and the debt service fund issue. As to the former issue, the district court recognized that manual section 233 "does not have the force of regulation because it was not subject to the notice and comment procedure which precedes adoption of regulations codified in [the Code of Federal Regulations]." *Id.* at 286. The district court nonetheless held that it was permissible for the agency to follow the manual in preference to GAAP. For the reasons stated in the part that follows, we disagree.

II

The amount the Department pays for services provided by hospitals such as Guernsey Memorial is fixed by statute at "the reasonable cost of such services, as determined under section 1395x(v) of [Title 42 of the United States Code]," if that cost does not exceed "the customary charges with respect to such services." 42 U.S.C. § 1395f(b)(1). "The reasonable cost of any services shall be the cost actually incurred," § 1395x(v) provides, "and shall be determined in accordance with regulations establishing the method or methods to be used . . . ."

"In prescribing the regulations," § 1395x(v) goes on to say, "the Secretary shall consider, among other things, the principles generally applied by national organizations . . . ." We can safely assume that "national organizations" keep their books in accordance with "generally accepted accounting principles."

The fact that the Secretary must "consider" GAAP in prescribing her regulations does not mean that GAAP must be adopted in the regulations, of course. But when one turns to Part 413 of Title 42 of the Code of Federal Regulations—a part devoted in its entirety to "Principles of Reasonable Cost Reimbursement"—one finds what appears to be a flat statement that generally accepted accounting principles "are followed." See 42 C.F.R. § 413.20, which is contained in a subpart dealing with "Accounting Records and Reports."

"The principles of cost reimbursement," § 413.20 (a) says, "require that providers [hospitals, *e.g.*] maintain sufficient financial records and statistical data for proper determination of costs payable [*i.e.*, reimburseable by HHS] under the program." The regulation continues as follows:

> "Standardized definitions, accounting, statistics, and reporting practices that are widely accepted in the hospital and related fields are followed. Changes in these practices and systems will *not* be required in order to determine costs payable under the principles of reimbursement." (Emphasis supplied.)

Where a hospital keeps its books on the accrual basis and in accordance with an approved method of cost-finding, changes not only are not required by the regulations, they do not seem to be permitted: "The cost data *must* be based on an approved method of cost finding and on the accrual basis of accounting." 42 C.F.R. § 413.24(a) (emphasis supplied). Section 413.24(b)(2) goes on to give this explanation of the accrual basis of accounting:

> "Under the accrual basis of accounting, revenue is reported in the period it is earned, regardless of when it is collected, and expenses are reported in the period in which they are incurred, regardless of when they are paid."

In general terms, the introduction to Part 413 explains, "the methods of reimbursement should result in current payment so that institutions will not be disadvantaged, as they sometimes are under other arrangements, by having to put up money for the purchase of goods and services well before they receive reimbursement."

It is undisputed, in the case at bar, that Guernsey Memorial Hospital keeps its books on the accrual basis of accounting and in accordance with generally accepted accounting principles. It is undisputed that the hospital put up money in 1985 or before for all

of the items at issue here, and it is undisputed that these costs were "incurred," under GAAP, in 1985.

Were it not for § 233 of the Provider Reimbursement Manual, any fair-minded person reading the regulations in the light of generally accepted accounting principles would have to conclude that Guernsey Hospital was entitled to reimbursement for its advance refunding costs in the year in which, under GAAP, the costs were deemed to have been incurred. But § 233, which deals specifically with advance refunding costs, calls for a departure from GAAP in this instance. "When a provider defeases or repurchases debt incurred for necessary patient care through an advance refunding," § 233.3 provides, "[u]namortized discounts or premiums (reduction of debt cancellation costs) and debt issue costs of the refunded debt must be amortized over the period from the issue date of the refunding debt to the date the holders of the refunded debt will receive the principal payment . . . ." Summing up the effect of this accounting treatment, § 233 explains that "[t]he effect of the above treatment is to implicitly recognize any gain or loss incurred as the result of an advance refunding over the period from the date the refunding debt is issued to the date the holders of the refunded debt receive the principal payment, rather than immediately."

Although this treatment of advance refunding costs is in conflict with GAAP, there is nothing irrational about it. A respectable argument can be made that the treatment required by § 233 of the manual squares with economic reality, and we do not doubt that the Secretary would have the power to promulgate an actual regulation embodying the substance

of § 233. The Secretary's problem, of course, is that she has not done so.

As the district court recognized in this case, the manual "does not have the force of regulation." 796 F.Supp. at 286. Issuance of the manual was not preceded by publication in the Federal Register of a notice of proposed rulemaking pursuant to 5 U.S.C. § 553(b). The public was not given advance notice of the terms or substance of any proposed rule on the treatment of advance refunding costs, or a description of the subjects and issues involved. See 5 U.S.C. § 553(b)(3). And interested persons were given no opportunity to submit written data, views, or arguments for consideration by the Secretary in advance of promulgation. See 5 U.S.C. § 553(c).

If § 233 of the manual were merely an "interpretative" rule, it would be valid without a formal rulemaking proceeding by reason of a statutory exception to the notice and comment requirements. See 5 U.S.C. § 553(b)(A). If the rule is substantive in character, however—if it is "legislative," in other words—the agency's failure to comply with the rulemaking requirements of the Administrative Procedure Act is fatal to its validity. See *State of Ohio Dep't of Human Services v. U.S. Dep't of Health & Human Services*, 862 F.2d 1228, 1233-37 (6th Cir. 1988). A rule that works a substantive change in existing regulations is clearly a legislative rule that must be adopted in accordance with the Administrative Procedure Act.

As one district court has noted, in holding against the Secretary in a case that is squarely in point here,

> "Where a [Providers Reimbursement Manual] provision exceeds its purpose and conflicts with

an existing regulation or statute, it is invalid under the APA. *See, e.g., National Medical Enters.* [*v. Bowen*], 851 F.2d [291] at 293 [(9th Cir.1988)] (PRM interpretations hostile to accrual accounting regulations will not be enforced since regulation and not PRM has force of law); *Vista Hill Found., Inc. v. Heckler*, 767 F.2d 556, 559-60 (9th Cir.1985) (court will defer to Secretary's interpretations only when consistent with statute and regulations); *Fairfax Nursing Center, Inc. v. Califano*, 590 F.2d 1297, 1301 (4th Cir.1979) (Secretary may not promulgate regulations and then change their meanings by interpretations or clarifications without formal notice or comment.)" *Mercy Hospital v. Sullivan*, Civil No. 90-0024 P, 1991 WL 104090 (D.Me. April 25, 1991).

Like the *Mercy Hospital* court, we believe that § 233 of the Providers Reimbursement Manual impermissibly changes the meaning of validly adopted regulations. *Accord: Baptist Hospital East v. Sullivan*, 767 F.Supp. 139 (W.D.Ky.1991); *Ravenswood Hospital Medical Ctr. v. Schweiker*, 622 F.Supp. 338 (N.D.Ill.1985). *Contra: Mother Frances Hospital of Tyler, Texas v. Shalala*, 818 F.Supp. 990 (E.D. Tex.1993).[2] The Secretary's argument to the contrary is not persuasive.

---

[2] The Court of Appeals for the Ninth Circuit has suggested, by way of dictum, that in the cost reimbursement context the Secretary can depart from GAAP only where the departure is authorized in a regulation. *Villa View Community Hosp., Inc. v. Heckler*, 720 F.2d 1086, 1093 n. 18 (9th Cir.1983). The Fourth Circuit has said that even if there are situations in which the Secretary may create a conflict with GAAP through

What the Secretary says, basically, is that the regulations relied on by the hospital deal only with the manner in which the hospital is to *report* its advance refunding costs. The regulations are silent as to the manner in which these costs are to be *reimbursed*, as we understand the argument; the manual simply clears up something that would otherwise have been ambiguous, according to the Secretary.

But the sentence in 42 C.F.R. § 413.20(a) that says standardized reporting practices "are followed" does not exist in a vacuum. The very first sentence of that section of the regulations begins with a reference to "[t]he principles of *cost reimbursement*." (Emphasis supplied.) The sentence that comes immediately after the sentence prescribing use of standardized reporting practices says that changes in these standardized practices "will not be required in order to determine *costs payable* [by HHS] *under the principles of reimbursement*." (Emphasis supplied.) The whole purpose of Part 413, as the introduction to that part explains, is to "set[] forth regulations governing Medicare payment" for services furnished, on a cost reimbursable basis, by hospitals and similar health care providers. 42 C.F.R. § 413.1(a).

The rule set forth in the manual ignores the structure of the regulations and assumes the existence of a regulatory ambiguity that we have not been able

---

interpretation of existing regulations, "the Secretary would be at the very limit of [her] authority in doing so." *Charlotte Memorial Hosp. & Med. Center v. Bowen*, 860 F.2d 595, 600 (4th Cir.1988). Interpretations departing from GAAP "would be subject to greater scrutiny than interpretations which are consistent with GAAP," the Fourth Circuit has said. *Id.*

to detect. Insofar as the manual provision may represent an interpretation of the regulations, it is neither reasonable nor persuasive—and such interpretations are not binding on the courts. *Ohio State University v. Secretary of HHS*, 996 F.2d 122, 124 (6th Cir.1993). We find nothing to the contrary in *Good Samaritan Hospital v. Shalala*, —— U.S. ——, 113 S.Ct. 2151, —— L.Ed.2d —— (1993), where the Supreme Court deferred to an agency interpretation which, while it was not the sole permissible interpretation of an ambiguous statute, gave "reasonable content to the statute's textual ambiguities." *Id.* at ——, 113 S.Ct. at 2162, quoting *Department of the Treasury, IRS v. FLRA*, 494 U.S. 922, 933, 110 S.Ct. 1623, 1629, 108 L.Ed.2d 914 (1990).

On July 13, 1992, subsequent to the district court's issuance of its opinion in the case at bar, the Provider Reimbursement Review Board considered another case concerning timing of Medicare reimbursement for an advance refunding loss. *Fort Worth Osteopathic Medical Ctr. v. Blue Cross & Blue Shield Assn.*, Board Dec.No. 90-0543. Over the dissent of one of the five members participating, the Board rejected the view (the view adopted, as the decision notes, by the district court in the instant case) that "42 C.F.R. § 413.20 pertain[s] only to record-keeping requirements and not to reimbursement." Slip Op. at 15. We find the Board's reasoning instructive:

> "In finding that 42 C.F.R. § 413.20 deals with record-keeping requirements and not reimbursement, the *Guernsey* court apparently concludes that the Medicare program has certain requirements for record-keeping and totally different requirements for reimbursement. The majority

> of the Board believes that the court's analysis fails to take into consideration the nexus between cost reporting and cost reimbursement.
>
> * * * * *
>
> "The majority of the Board believes that the purpose of cost reporting is to enable a hospital's costs to be known so that its reimbursement can be calculated. For that reason, there must be some consistency between the fundamental principles of cost reporting and those principles used for cost reimbursement.
>
> * * * * *
>
> ". . . 42 C.F.R. § 413.24 requires that cost data submitted must be based on the accrual basis of accounting which is recognized as the most accurate basis for determining costs. Under the accrual basis of accounting, expenses are to be reported in the period in which they are incurred, regardless of when paid. Under the accrual basis of accounting, the loss on defeasance was incurred in the period when the bonds were defeased. The majority of the Board believes that 42 C.F.R. § 413.24 requires that the Secretary determine cost on the accrual basis unless a specific regulation to the contrary has been promulgated." Slip Op. at 16.

The "nexus" that exists in the regulations between cost reporting and cost reimbursement is too strong, in our view, to be broken by a rule not adopted in accordance with the rulemaking requirements of the Administrative Procedure Act. Insofar as the decision issued by the district court in this case holds otherwise, the decision is reversed.

III

Guernsey Hospital's 1985 trust indenture created a debt service fund for payment of amounts due on the refunding bonds. Two separate accounts were established within that fund: one for the repayment of principal and one for the payment of interest. Guernsey began to deposit money into these accounts immediately upon the issuance of the 1985 bonds. From February 1 to December 31, 1985, the investment yield on the money in the interest account came to $24,874. The hospital did not offset this amount against its allowable interest expense. The fiscal intermediary took exception to this, reducing the reimbursement for interest expense in 1985 by about $12,000.

The Provider Reimbursement Review Board decided this issue in favor of the hospital, holding that no offset was required. Reversing the Board's decision, the Administrator held that an offset was required. Upon review, the district court agreed with the Administrator.

For reasons stated by the district court at 796 F.Supp. 292-93, we affirm the decision of the district court on this issue.

IV

In summary, we REVERSE the district court decision insofar as the issue discussed in Part II hereof is concerned, and we AFFIRM it insofar as the issue discussed in Part III is concerned. The case is REMANDED to the district court for entry of summary judgment in favor of the appellant hospital on the former issue.

APPENDIX B

UNITED STATES DISTRICT COURT
S.D. OHIO, E.D.

No. C2-90-828

GUERNSEY MEMORIAL HOSPITAL, PLAINTIFF

v.

LOUIS W. SULLIVAN, M.D., SECRETARY OF HEALTH AND HUMAN SERVICES, DEFENDANT

March 30, 1992

MEMORANDUM AND ORDER

HOLSCHUH, Chief Judge.

I.

Guernsey Memorial Hospital, a nonprofit acute care hospital located in Cambridge, Ohio, filed this action seeking review of a final decision of the Healthcare Financing Administration (HCFA) administrator dealing with two cost reimbursement issues arising under Medicare. The parties agree that this court has jurisdiction to review that decision under 42 U.S.C. § 1395*oo*. The record of administrative proceedings has been filed with the court, and the parties have each moved for summary judgment,

supplementing their respective filings as recently as March 12, 1992, with citations to additional decisions of the Provider Reimbursement Review Board, the HCFA administrator, two other district courts, and the United States Supreme Court. The court's review of the Secretary's decision is not *de novo*, but is limited to determining whether the Secretary's action was unsupported by substantial evidence, or was arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law. *See* 42 U.S.C. § 1395*oo*(f)(1); *Memorial Hospital/Adair County Health Center v. Bowen*, 829 F.2d 111, 116 (D.C. Cir.1987).

II.

The facts in this case are not in dispute. In 1972, Guernsey Hospital issued $7,600,000 in bonds to finance capital improvements. In 1982, it issued another $10,410,000 of bonds for similar purposes. In 1985, in order to take advantage of more favorable interest rates which would, in its view, save it approximately $12,000,000 in debt service over the life of the two prior bond issues, eliminate certain restrictions on additional borrowing contained in those debt instruments, and free up funds to buy medical equipment, the hospital participated in a new bond issue in the amount of $15,375,000.

The refinancing arrangement involved, *inter alia*, deeding the hospital to the City of Cambridge and leasing it back. It also required the hospital to deposit $16,011,200 in an escrow account under the control of BancOhio National Bank as trustee. In exchange for doing so, the hospital was released of any further obligation to the bondholders who purchased hospital bonds in 1972 and 1982. The trustee

would use the money in escrow to "advance purchase" some or all of the old bonds, and was also entitled to use the rent payments made by the hospital to the city for purposes of repaying the new bonds. To that end, a Debt Service Fund, or DSF, was created, divided into two separate accounts, one for the repayment of principal on the bonds, and one for the repayment of interest.

Because this refinancing occurred in 1985, Guernsey Hospital was required, under applicable regulations, to report the impact of the refinancing pursuant to Generally Accepted Accounting Procedures (GAAPs). The parties agree that, under GAAPs, the hospital properly reported a loss of $672,581 in 1985. Guernsey Hospital sought to include this loss as an operating cost for 1985, and to receive appropriate reimbursement for the loss under the Medicare program.

In Ohio, requests for reimbursement under Medicare are channeled through a fiscal intermediary, which has primary responsibility for determining what costs will be reimbursed. In this case, the fiscal intermediary was Blue Cross and Blue Shield/Community Mutual Insurance Company. That entity determined that, under provisions set forth in the Provider Reimbursement Manual, the loss could not be taken in full in 1985, but rather was required to be amortized over a period of years. Guernsey Hospital appealed that decision to the Provider Reimbursement Review Board, which overruled the fiscal intermediary. The Board, in turn, was reversed by the HCFA administrator, who concluded, like the fiscal intermediary, that the loss would have to be amortized. That issue is the primary one presented for review.

Guernsey Hospital has also asked this court to review a second decision of the administrator which, again, upheld the action of the fiscal intermediary and overruled the Provider Reimbursement Review Board. A certain amount of interest was earned on the interest portion of the Debt Service Fund during 1985. The Secretary offset that interest against other interest expenses incurred by Guernsey Hospital. The hospital contends that the Debt Service Fund, including both the principal account and the interest account, is a "qualified funded depreciation account." If that is so, under applicable regulations, the interest earned in such an account may not be used by the Secretary to offset other interest expenses claimed by the hospital. As with the first issue presented for review, the facts concerning this matter are not in dispute. Rather, it is the Secretary's interpretation of applicable regulations which Guernsey Hospital seeks to have this court overturn.

III.

As with most cases involving actions by the Secretary of Health and Human Services, there are three sources of authority which must be examined. The first is the governing statute; the second consists of the implementing regulations; and the third is the Secretary's interpretation of those regulations. Because the two reimbursement issues in this case are governed by different sets of regulations, the Court will treat each separately. The court will also, prior to analyzing the Secretary's action in this case, enunciate the appropriate standard for review of the Secretary's interpretation of the regulations and statute at issue.

A. *The Bond Refinancing Issue*

1. *Applicable Statutes, Regulations and Interpretations.*

The basic statutory authority for reimbursement of reasonable costs by qualified healthcare providers is 42 U.S.C. § 1395x(v). The statute provides, in pertinent part:

> "(1)(A) The reasonable costs of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services; . . . In prescribing the regulations referred to in the preceding sentence, the Secretary shall consider, among other things, the principles generally applied by national organizations or established prepayment organizations (which have developed such principles) in computing the amount of payment . . . to providers of services on account of services furnished to such recipients by such providers."

Acting under this statutory grant of authority, the Secretary has promulgated regulations relating to reimbursement of Medicare providers. Those regulations now appear at 42 C.F.R. Part 413. The general principles for cost reimbursement are set forth in 42 C.F.R. § 413.5, which provides that "[a]ll necessary and proper expenses of an institution in the production of services . . . are recognized." The par-

ties agree that the refinancing cost incurred by Guernsey Hospital is a cost which is reimbursable under this general principle. As noted above, the disagreement involves the timing of reimbursement. The parties appear to agree that there is no specific regulation which addresses this issue.

The more general regulation dealing with the timing of payments is 42 C.F.R. § 413.20, which is contained in Subpart B of the regulations ("Accounting Records and Reports"). Section 413.20(a) requires that providers "maintain sufficient financial records and statistical data for proper determination of costs payable under the program." It then provides:

> "Standardized definitions, accounting, statistics, and reporting practices that are widely accepted in the hospital and related fields are followed. Changes in these practices and systems will not be required in order to determine costs payable under the principles of reimbursement. Essentially the methods of determining costs payable under Medicare involve making use of data available from the institution's basis accounts, as usually maintained, to arrive at equitable and proper payment for services to beneficiaries."

Further, 42 C.F.R. § 413.24 requires providers who receive payment on the basis of reimbursable costs to provide adequate cost data based upon verifiable financial and statistical records. That section requires that the accrual method of accounting be followed which, according to § 413.24(b)(2), means that "revenue is reported in the period when it is earned . . . and expenses are reported in the period in which they are incurred. . . ."

These regulations, of course, must be applied by fiscal intermediaries who administer the Medicare program. To assist them in doing so, the Secretary has also published the PRM, which does not have the force of regulation because it was not subject to the notice and comment procedure which precedes adoption of regulations codified in CFR. Section 233 of the PRM, published in May, 1983 and in effect when Guernsey Hospital refinanced its debt, deals specifically with advance refunding. Section 233.3 requires that debt issue costs on the "refunding debt" be amortized over the life of that debt, and that call premiums or penalties of serial bonds must be prorated over the scheduled maturity or recall dates of those bonds. As set forth at the conclusion of that section, "[t]he effect of the above treatment is to implicitly recognize any gain or loss incurred as the result of an advance refunding over the period from the date the refunding debt is issued to the date the holders of the refunded debt receive the principal payment, rather than immediately." (Administrative Record at 991-92).

One further matter is relevant to this issue. The parties also agree that current GAAPs, represented by Opinion No. 26 of the Accounting Principles Board and Statement No. 76 of the Financial Accounting Standards Board, would recognize the entire cost of the refunding debt as an expense in the year incurred. Thus, a very narrow issue is presented for review: is the Secretary required, by the applicable statute and regulations, to treat Guernsey Hospital's 1985 refinancing expense in accordance with generally accepted accounting principles, or may the Secretary, following the PRM, elect a differ-

ent treatment? The court now turns to the appropriate legal analysis of this question.

2. *Legal Standard Applicable.*

The arguments raised in this case require several levels of analysis. There are three sources of law to which the court must look in deciding which party's interpretation of federal law is correct. The first is the governing statutes; the second is the implementing regulations; and the third is the agency's interpretation of those regulations. A somewhat different set of legal precepts applies to each level of analysis.

First, with respect to the interpretation of the statutes as enacted by Congress, "it is elementary that '[t]he starting point in every case involving construction of a statute is the language itself.'" *Southeastern Community College v. Davis*, 442 U.S. 397, 405, 99 S.Ct. 2361, 2366, 60 L.Ed.2d 980 (1979), *quoting Blue Chip Stamps v. Manor Drug Stores*, 421 U.S. 723, 756, 95 S.Ct. 1917, 1935, 44 L.Ed.2d 539 (1975) (Powell, J., concurring); *see also United States v. Ron Pair Enterprises, Inc.*, 489 U.S. 235, 241, 109 S.Ct. 1026, 1030, 103 L.Ed.2d 290 (1989). If the statutory language is plain, it conclusively establishes the intent of the legislature except in those rare cases where the result of giving the statute its plain meaning is demonstrably different from the clear intent of the drafters of the statute. *United States v. Ron Pair Enterprises, Inc.*, 489 U.S. at 242, 109 S.Ct. at 1031; *see also United States v. Underhill*, 813 F.2d 105, 111 (6th Cir.), *cert. denied sub nom. Rayburn v. United States*, 482 U.S. 906, 107 S.Ct. 2484, 96 L.Ed.2d 376 (1987).

Strict adherence to the rule that a statute is to be given its plain meaning has significant desirable con-

sequences. First, it discourages judicial legislating, thereby keeping the legislative power vested in the appropriate and popularly-elected branch of government. It also encourages the drafters of legislation to speak plainly and precisely, knowing that if they do so, the courts will enforce the law as it has been clearly articulated. Finally, it promotes certainty in the law, eliminating the need for resort to other interpretive devices such as a review of legislative history, which is usually a grab-bag from which support for almost any interpretation of a statute can readily be plucked. There are cases, however, where Congress has not clearly expressed in the language of a statute what result was intended. "Where the literal language of the statute does not conclusively reveal legislative intent, the courts must look beyond literal meaning, analyzing the provision in context with the whole." *In re Arnett*, 731 F.2d 358, 361 (6th Cir.1984). Where the context of an entire statute does not reveal the meaning of a particular provision, resort to extrinsic aids to demonstrate Congressional intent, such as legislative history, can be an appropriate way to determine legislative intent, or at least to support a particular reading of a statute where the intent of the drafters is sufficiently obscure that it can never be divined with certainty.

The above rules of statutory construction apply in all cases, but the court must be mindful of some additional rules when interpreting a statute which has previously been construed, through the process of enacting regulations, by the agency charged with the duty to enforce the statute. It has been held that "[w]hen the issue is the validity of a regulation issued under a statute that agency is charged with administering, it is well established that the agency's

construction of the statute is entitled to great weight." *Melamine Chemicals, Inc. v. United States*, 732 F.2d 924, 928 (Fed.Cir.1984). Nevertheless, the Court must be mindful of its own duty to interpret the statute according to its plain meaning. "Although an agency's interpretation of the statute under which it operates is entitled to some deference, 'this deference is constrained by our obligation to honor the clear meaning of the statute, as revealed by its language, purpose, and history.'" *Southeastern Community College v. Davis*, 442 U.S. 397, 411, 99 S.Ct. 2361, 2369, 60 L.Ed.2d 980 (1979), *quoting Teamsters v. Daniel*, 439 U.S. 551, 556 n. 20, 99 S.Ct. 790, 800 n. 20, 58 L.Ed.2d 808 (1979). Consequently, although in an appropriate case the party attacking an agency's interpretation of a statute through the issuance of a regulation bears a heavy burden of persuasion, the Court "will not abdicate to federal agencies the interpretation of regulations which are promulgated pursuant to an empowering statute. . . . Any regulation promulgated pursuant to rule making authority conferred by statute assumes the force of law only to the extent that it is consistent with the statutory scheme it was designed to implement." *Mitchell v. White Motor Credit Corp.*, 627 F.Supp. 1241, 1249 (M.D.Tenn.1986).

In this case, the Court must deal not only with the intent of Congress in passing the statute involved, and with the reasonableness of the Secretary's interpretation of that statute through the adoption of regulations, but also the issue of interpreting the meaning of those regulations in light of the Secretary's own construction of them. It is also well-established that an administrative agency's interpretation of its own regulations is entitled to substantial deference.

Chevron USA, Inc. v. National Resources Defense Council, Inc., 467 U.S. 837, 104 S.Ct. 2778, 81 L.Ed. 2d 694 (1984); *Bradley v. Austin*, 841 F.2d 1288 (6th Cir. 1988). Again, however, the Court is constrained to reject an agency's interpretation of a regulation if the interpretation is clearly at odds with the language of the regulation itself—that is, an interpretation is acceptable only if it "does no violence to the plain meaning of the [regulatory] provision." *University of Cincinnati v. Bowen*, 875 F.2d 1207, 1209 (6th Cir.1989), *quoting Deukmejian v. Nuclear Regulatory Commission*, 751 F.2d 1287, 1310-11 (D.C.Cir.1984); *see also Fluor Constructors v. Occupational Safety and Health Review Commission*, 861 F.2d 936, 939 (6th Cir.1988).

It is with these guiding principles in mind that the Court now turns to the precise legal issues presented by the 1985 refinancing.

3. *Analysis.*

It is helpful to set forth, briefly, the details of each party's position and the support which each has marshalled. The court begins with the Hospital's position, which is, in essence, the position taken by the PRRB in several different matters presenting essentially the same facts, and which has been adopted by judicial decisions from the Western District of Kentucky and the District of Maine. Relying primarily upon the rationale of decisions such as *Charlotte Memorial Hospital and Medical Center v. Bowen*, 860 F.2d 595 (4th Cir.1988), the Hospital claims that the Medicare Act requires both that reasonable costs of Medicare providers be reimbursed, and that the Secretary promulgate regulations after considering accounting practices which are generally followed in the industry.

Building upon that statutory mandate, the Secretary's regulations (primarily 42 C.F.R. §§ 413.20 and 413.24) provide that, unless there is some other regulation to the contrary, the Secretary shall reimburse costs based upon the accrual method of accounting and in accordance with generally accepted accounting principles. There is no promulgated regulation which provides for a different treatment of costs incurred in refinancing. Consequently, any effort by the Secretary, through the PRM or otherwise, to treat the refinancing costs other than in accordance with GAAPs is "contrary to the law" in the sense that it contradicts the regulations which have been promulgated. The keystone to this argument is, of course, the claim that "where the specific regulation is silent on the subject [of the particular costs involved], as it is here, the regulation establishing general principles for cost reporting must be deemed applicable," and that the regulation requires the Secretary to follow GAAPs. *National Medical Enterprises v. Bowen*, 851 F.2d 291, 294 (9th Cir.1988).

The Secretary agrees that the Medicare Act requires both reimbursement of reasonable costs and consideration of GAAPs. The Secretary further agrees that the accrual method of accounting should ordinarily be followed, and that hospitals are required to *report* their costs in accordance with GAAPs. However, the Secretary views 42 C.F.R. § 413.20 as a reporting requirement, and not as a mandate that costs be reimbursed in the same fashion as they are required to be reported. Rather, the Secretary's position is that if any other permissible purpose served by Medicare reimbursement, such as prevention of cross-subsidization or recharacterization of

the economic reality of delivery of services to patients, is served, the Secretary can choose to depart from GAAPs so long as that departure is not arbitrary. The Secretary's position is perhaps best stated by the following quotation from *American Medical International, Inc. v. Secretary of HEW*, 466 F.Supp. 605, 623 (D.D.C.1979); "this provision [42 C.F.R. § 413.20] only provides that accepted accounting practices be used in uniform record-keeping, not in determining costs allowable under the Medicare Act," *aff'd*, 677 F.2d 118 (D.C.Cir.1981). Because the regulation does not, in the Secretary's view, mandate slavish adherence to GAAPs, and because the Secretary has a reasonable basis for concluding that the "loss" experienced by Guernsey Hospital in 1985 relates to future benefits—i.e., the reduction in interest payments over the course of many years—the Secretary did not act arbitrarily in determining, in accordance with the PRM, that the cost must be amortized. The Secretary stresses that amortizing this cost does not violate principles of accrual accounting, and the issue here is not whether the accrual method is being followed, but whether the Secretary is free to follow the minority view of the FASB and require that the 1985 loss be amortized.

The two district courts which have considered this precise issue have both adopted Guernsey Hospital's position. The more detailed of the two decisions is Magistrate Judge Cohen's opinion in *Mercy Hospital v. Sullivan*, No. 90-0024 P, 1991 WL 104090 (D.Me. April 25, 1991) *aff'd Mercy Hospital v. Sullivan*, No. 90-0024 P (September 13, 1991) (Carter, Chief Judge). *Mercy Hospital* dealt with a slightly different situation, in that the PRM sections in effect at that time allowed the Secretary to treat a loss on re-

financing by amortizing it over years, but also allowed the Secretary to treat a gain on refinancing by recognizing it entirely in the year in which the gain is recognized under GAAP. Otherwise, the facts are the same.

Mercy Hospital first rejected the Secretary's argument that to recognize the full loss in one year would violate the statutory prohibition against cross-subsidization, primarily bcause there was no evidence in that case that the hospital did not properly allocate the expense, even if it was claimed all in one year, as between Medicare and non-Medicare patients. The same is true in this case. The *Mercy Hospital* court further concluded that other regulations, including particularly 42 C.F.R. § 413.5, should be taken into account. That regulation requires payment to be made on the basis of current costs, and should not disadvantage providers by requiring them to pay out money well before reimbursement is received. Consequently, the court's conclusion was that the regulations, taken as a whole, did not require the Secretary to amortize the cost of refinancing over a period of years, and that to recognize it in one year would not violate any particular regulation.

That, of course, does not answer the precise question posed, which is whether the Secretary may reasonably amortize the cost even though he is not required to do so. In *Mercy Hospital*, the court read the applicable sections of the PRM as dealing only with the reasonableness of refinancing costs and not the timing of reimbursement. Assuming, however, that § 233 was a clarification of the Secretary's position and supported amortization of the costs, the Court concluded, relying upon *Charlotte Memorial Hospital, supra*, that such an approach was "contrary

to the applicable regulations and impermissible under the [Administrative Procedure Act]." In conclusion, *Mercy Hospital* held that the Secretary had explicitly promulgated regulations generally applying GAAPs, and that the Secretary could depart from such principles only by promulgating other regulations "providing for another method of accounting and reimbursement."

Mercy Hospital rejected the Secretary's argument that § 413.20 relates only to the record-keeping practices of the hospitals, relying upon the reasoning in *St. Luke's Hospital v. Secretary of Health and Human Services*, 632 F.Supp. 1387, 1391 (D.Mass. 1986), *vacated on other grounds*, 810 F.2d 325 (1st Cir.1987), to the effect that a separation between record-keeping requirements and reimbursement procedures is "illogical." That court's interpretation of § 413.20 was that presenting financial records in accordance with GAAPs was mandated precisely because the Secretary fully intended to reimburse institutions under the same procedures, and that to suggest that the Secretary retained discretion to do otherwise is "contrary to the structure of the regulations." *Mercy Hospital*, slip op. at 21. Recognizing *Mercy Hospital* as the strongest decision in support of the Hospital's position, the question becomes whether this court is persuaded by its rationale, or whether there are any significant points in the analysis at which this court and *Mercy Hospital* part company. The court concludes, for the following reasons, that *Mercy Hospital* is not persuasive precedent, and that the Secretary's decision in this case must be upheld because it is a permissible interpretation of the applicable statute and regulations.

Mercy Hospital and other cases which have limited the Secretary to the use of GAAPs in the absence of a specific regulation to the contrary all rely on the Ninth Circuit's decision in *Villa View Community Hospital v. Heckler*, 720 F.2d 1086 (1983). That case, however, did not hold that the Secretary was required to rely on GAAPs, because the Secretary did not depart from those principles in that case. The court merely noted in a footnote that the Secretary normally reimbursed costs based upon GAAPs. In the same footnote, the court noted that the Secretary had, by notice published in the Federal Register, specifically reserved the right to reimburse costs differently based upon actual patient care costs if GAAPs did not produce a satisfactory result. *Villa View Community Hospital*, 720 F.2d at 1093 n. 18. The Secretary correctly points out that cases decided after *Villa View*, such as *National Medical Enterprises v. Bowen*, 851 F.2d 291 (9th Cir.1988), *HCA Health Services of Midwest, Inc. v. Bowen*, 869 F.2d 1179 (9th Cir.1989), and *Charlotte Memorial Hospital and Medical Center v. Bowen*, 860 F.2d 595 (4th Cir.1988), all cite to *Villa View* as standing for the principle that the Secretary must, in the absence of regulations to the contrary, apply GAAPs.

Guernsey Hospital argues that, whether *Villa View* stands for the proposition it is often cited for or not, the plethora of cases after *Villa View* which have accepted Guernsey Hospital's position suggests that the position has now become law. Of course, these cases are persuasive only to the extent that their reasoning strikes this court as fundamentally sound. The soundness of their reasoning depends, in turn, on whether they have properly construed the statute

and regulations as prohibiting the Secretary from taking the opposite view which, in turn, means that the Secretary's interpretation of the regulations must be manifestly unreasonable. The court does not believe that it is.

The central focus of this analysis is 42 C.F.R. § 413.20. The decisions above have relied heavily upon the apparently mandatory provision that "[s]tandardized definitions, accounting, statistics, and reporting practices that are widely accepted in the hospital and related fields *are followed.*" (Emphasis supplied). The title of that section, however, is "Financial Data and Reports," and it appears in Subpart B of the regulations which is entitled "Accounting Records and Reports." The first sentence of Section 413.20(a) clearly refers to the requirement that "providers maintain sufficient financial records and statistical data for proper determination of costs payable under the program." The balance of § 413.20 deals with the frequency with which providers are to supply cost reports, record-keeping requirements for new providers, and continuing provider record-keeping requirements. Subsection (e) permits program payments to be suspended if a provider does not maintain adequate records. None of the provisions in § 413.20, however, is either titled in a way that suggests it deals with cost reimbursement principles, or deals specifically with cost reimbursement. General rules of cost reimbursement are set forth in Subpart A of the regulations, and particularly in § 413.5, which lists six general objectives of cost reimbursement. None of the those objectives makes any specific reference to GAAPs, and § 413.5 (b)(4) points out that there should be "sufficient flexibility in the methods of reimbursement to be

used. . . ." Given the structure of these regulations, the requirement in the statute that the Secretary "consider," but not necessarily follow without deviation, generally accepted accounting principles, and the deference given to the Secretary's interpretation of these regulations, this court cannot say that the Secretary's conclusion that GAAPs need not be followed in all cases is an impermissible interpretation.

The conclusion that the Secretary is not inescapably bound by GAAPs does not, however, mean that every decision to depart from those principles is reasonable. In order for the Secretary's decision to be immune from reversal on grounds that it is arbitrary or capricious, the Secretary must have a permissible rationale for choosing to use some method other than GAAPs to determine when a particular allowable cost is reimbursable. *See, Charlotte Hospital, supra,* which concluded that the specific departure from GAAPs in that case was unreasonable. It is the court's view that the Secretary has a rational basis for concluding that this particular loss should be amortized over the life of the pre-existing debt, and that his departure from GAAPs cannot be considered arbitrary or capricious.

ABP No. 26 was apparently developed as a result of accountants' concerns that similar types of transactions be given similar treatment. For example, if pre-existing debt is cancelled in a particular year by recalling the debt, any costs associated with that transaction are recognized in the year of the recall. In a case such as this, where the debt is not immediately recalled but provisions are made for its repayment in the future, the transaction is treated in the same way. The Secretary concluded, however, that this approach focuses on the immediate reduc-

tion in the net worth of the provider from the transaction, but does not focus upon the fact that the benefits of the transaction are spread out over a number of years. The Secretary has chosen to characterize a transaction such as this one as "an adjustment to the Provider's capital structure" (Tr. 7), but, in terms of its effect on patient care services, the Secretary concluded that "[t]he loss is more closely related to the years over which the original bond term extended. . . ." *Id.* This is also the minority view expressed by the three dissenting members of the Board which adopted ABP No. 26.

The fact that an argument can be made for amortizing this particular loss, and that there was some disagreement even among those accountants who promulgated GAAPs, convinces the court that the Secretary did not act in an arbitrary or capricious manner in choosing to follow the minority viewpoint. The Secretary also argues, of course, that to recognize the entire loss in the year of refinancing would violate the "cross-subsidization" principles of the Medicare Act. That argument was considered and rejected in the *Mercy Hospital* decision, and the court need not consider it here. It is enough to say that the Secretary has a rational basis for concluding that, by amortizing this particular cost, he has more closely approximated the impact of the transaction upon the provider's cost of patient care. If the evidence of record suggested that rational accountants could not disagree on this point, and that the only possible way of treating this cost was to recognize it in full in the year in which it was incurred, the Secretary's decision might be said to be arbitrary. That is not this case, and the court is not free to substitute

its view for that of the Secretary when the Secretary has not acted irrationally. For these reasons, the court concludes that the Secretary's decision as to the first issue, the timing of the recognition of the loss incurred as a result of the 1985 refinancing, must be affirmed.

B. *The Debt Service Fund Issue*

The nature of this issue is relatively straightforward. Obviously, Guernsey Hospital is required to make repayments both of principal and interest on the new bonds. Two separate accounts have been set up to accumulate funds for such repayment. One is to be used exclusively for accumulation of money to repay capital, and the other is to be used to accumulate money to repay interest.

Under regulations now found at 42 C.F.R. § 413.134(e), the Secretary strongly recommends funding of depreciation. As an incentive, § 413.134 (e)(1) provides that "investment income on funded depreciation is not treated as a reduction of allowable interest expense." § 413.134(e)(2)(i) states that the Secretary considers funded depreciation available "for use in the acquisition or replacement of depreciable assets related to patient care" or "for other capital purposes related to patient care." Section 413.134(e)(3) defines proper and improper withdrawals from funded depreciation, distinguishing between proper withdrawals, which are made for the acquisition or replacement of depreciable assets or for other capital purposes related to patient care, and improper requirements, which are all other withdrawals. If an improper withdrawal is made, regulations require that appropriate adjustments be made

in any previously-permitted exemption of the earnings from reducing allowable interest expense.

In this case, the Secretary treated the principal account as a funded depreciation account, since it was being used to repay the principal of obligations which were used to purchase depreciable assets relating to patient care. The Secretary concluded, however, that the interest account was not entitled to similar treatment, because it was simply being used to pay interest on that capital obligation. Guernsey Hospital contends that the interest on the obligation is being accumulated and paid "for other capital purposes relating to patient care" because it is so closely associated with the debt itself. The PRRB apparently adopted this argument, relying on a previous board decision concluding that a single debt service fund which was used to pay both interest and principal met the requirements of a funded depreciation account. Seeing no practical difference between a single fund and separate accounts, the Board concluded that the earned interest should not be used as an offset against otherwise allowable interest expense. The administrator, relying on the language of the regulations and a decision in *Good Samaritan Hospital v. Blue Cross Association/Mutual Hospital Insurance, Inc.*, PRRB Decision No. 79-D80 (November 26, 1979), *aff'd* HCFA Admin. Decision (January 23, 1980), reversed. The parties' arguments in this court are the same as those advanced below.

Again, the court must determine whether the Secretary's decision to refuse to recognize the interest account as a funded depreciation account is arbitrary, capricious, or otherwise not in accordance with law. The applicable regulations, of course, ap-

pear to allow for some flexibility, permitting an account to be so regarded when it is used either for the accumulation of funds to purchase depreciable assets related to patient care or for "other capital-related purposes" so related. The Secretary concluded that repayment of the principal amount of borrowing which was used to purchase depreciable assets was a "capital-related purpose." The question becomes whether interest on that same obligation is necessarily a "capital-related purpose" or whether the Secretary could, without running afoul of the regulations, properly characterize it as something else.

Again, this is an area where the Secretary's decision, in order to be reversed by this court, must possess an element of arbitrariness. It appears that reasonable minds could differ as to whether the interest being repaid was strictly for a "capital-related purpose" or whether it was simply an ordinary interest expense on borrowed funds. The only decision in the record which appears to relate to this issue is the *Good Samaritan* decision cited above. In that case, a "Lease Reserve Account" which accumulated money to be used to repay borrowing was treated as a funded depreciation account, although there existed the possibility that some of the money would be used to pay interest on that borrowing. The Secretary concluded that the existence of that possibility, alone, did not disqualify the interest earned on the fund from favorable treatment, but also stated that if a withdrawal from the fund was used for an improper purpose, such as the payment of interest, a retroactive adjustment would be required.

Good Samaritan is consistent with the position taken by the Secretary in this case. There, because it was unclear whether the money in the Lease Re-

serve Account which had been established would be used to pay interest or principal, the Secretary chose to wait until withdrawals were made and to make appropriate adjustments at that time depending upon the purpose for which the funds were used. Here, by contrast, the interest account was established for the sole purpose of paying interest on the refunding bonds. Guernsey Hospital has not suggested that the funds could properly be used for any other purpose. Under those circumstances, the Secretary need not wait until withdrawals are made in order to identify the purpose of the money, and then make a retroactive readjustment. Rather, he can determine now that the funds will be used only to pay interest. The court is not convinced that the Secretary acted arbitrarily or in violation of any applicable regulation by refusing to consider this interest-only account as sufficiently related to a capital expenditure for patient care purposes as to mandate that it receive the same favorable treatment which is offered as an incentive to hospitals to fund depreciation on capital assets. That being so, the Secretary's decision on this issue will be affirmed as well.

IV.

Based upon the foregoing, the motion of plaintiff, Guernsey Memorial Hospital, for summary judgment, is DENIED. The motion of the defendant, Louis W. Sullivan, M.D., Secretary of Health and Human Services, is GRANTED. The Clerk is directed to enter judgment in favor of the defendant.

APPENDIX C

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

No. 92-3563

GUERNSEY MEMORIAL HOSPITAL,
PLAINTIFF-APPELLANT

v.

SECRETARY OF HEALTH AND HUMAN SERVICES,
DEFENDANT-APPELLEE

ORDER

[Filed Oct. 04, 1993]

BEFORE: JONES and NELSON, Circuit Judges; and LIVELY, Senior Circuit Judge.

The court having received a petition for rehearing en banc, and the petition having been circulated not only to the original panel members but also to all other active judges of this court, and no judge of this court having requested a vote on the suggestion for rehearing en banc, the petition for rehearing has been referred to the original hearing panel.

The panel has further reviewed the petition for rehearing and concludes that the issues raised in the

petition were fully considered upon the original submission and decision of the case. Accordingly, the petition is denied.

ENTERED BY ORDER OF THE COURT

/s/ Leonard Green
LEONARD GREEN
Clerk

APPENDIX D

Health Care Financing Administration

Decision of the Administrator

IN THE CASE OF:

GUERNSEY HOSPITAL
PROVIDER

vs.

BLUE CROSS AND BLUE SHIELD ASSOCIATION/
COMMUNITY MUTUAL INSURANCE COMPANY
INTERMEDIARY

Claim for: Provider Cost Reimbursement Determination of Reasonable Costs for Cost Reporting Period(s) Ending

December 31, 1985

Review of:

PRRB Decision No. 90-D50

Dated: August 16, 1990

This case is before the Administrator, Health Care Financing Administration (HCFA), for review of the decision entered by the Provider Reimbursement Review Board (PRRB). The review is during the 60-day period in § 1878(f)(1) of the Social Security Act, as amended [42 USC 1395oo(f)]. The Intermediary submitted comments requesting reversal of both issues in the PRRB's decision. On August 31, the parties were notified of the Administrator's intention to review the PRRB's decision. The Bureau of Policy Development (BPD) submitted comments requesting reversal of the PRRB's decision. The Provider submitted comments requesting affirmation. Accordingly, the case is now before the Administrator for final administrative decision.

THE ISSUES AND PRRB'S DECISION

Issue No. 1

Issue No. 1 concerns whether Medicare reimbursement for a loss on defeasance, i.e. the advance refunding of bonds, should be governed by generally accepted accounting principles (GAAP), or by HCFA policy, as expressed in the Provider Reimbursement Manual (HIM-15). The PRRB held that GAAP applied and the loss was allowable in the fiscal period in which the refinancing occurred. In finding the loss allowable, the PRRB noted that it met the criteria for an allowable cost under 42 CFR 405.451.[1]

The PRRB also relied upon GAAP, as enunciated in Accounting Principles Board (APB) Opinion No. 26, which it found to conform to the documentation requirements in 42 CFR 405.406 and 405.453.[2] The PRRB noted that when the Medicare program does not specify the treatment of the costs arising from a transaction, it is required to use GAAP. Further, the loss on defeasance resulted from the change in

---

[1] Recodified at 42 CFR 413.9.

[2] Recodified at 42 CFR 413.20 and 413.24, respectively.

the market value of the Provider's debt; therefore, the loss is more appropriately related to prior periods than future periods.

Issue No. 2

Issue No. 2 concerns whether a debt service fund (DSF) required by a bond issue to pay interest expense on the bonds should be treated as a funded depreciation account. The PRRB held that the debt service fund established to repay the interest expense on the refunded bonds qualifies as a funded depreciation account. Therefore, the investment income earned in the account need not be offset against allowable interest expense.

SUMMARY OF COMMENTS

Issue No. 1

The Intermediary urged reversal stating that it properly applied the provisions of § 233 of the Manual. Amortization of the loss over future periods is required as it relates to the care of Medicare beneficiaries over a period of years; not just to the period of the refunding. The Intermediary noted the similarity of the facts in this case to those in *Shawnee Mission*, PRRB Decision No. 83-D54, *Mercy Hospital*, PRRB Decision No. 89-D64 and *Baptist Hospital*, PRRB Decision No. 89-D65, in which the Administrator required amortization.

The Provider, requesting affirmation, noted that the PRRB's decision responded to the Administrator's arguments in *Mercy* and *Baptist*. The Provider also cited *Ravenswood Hospital Medical Center v. Schweiker*, 662 F. Supp. 338 (N.D. Ill. 1985), as a persuasive authority in a similar factual context.

The BPD requested reversal stating that § 233 of the Manual was properly applied in this case. This section would amortize a loss incurred on the advance refunding of debt over the future periods to which it relates. The loss incurred on the advance refunding relates to the patient care services provided over the term of the debt, not just to the year in which the refinancing occurred. BPD also noted that it structured the provisions of § 233 in accordance with industry consultation.

Issue No. 2

Both the Intermediary and BPD requested reversal, stating that under § 226 of the Manual, and prior Administrator's decisions, the payment of interest expense is not a proper use of funded depreciation. To the extent funds are used for this purpose, offset is required. The Provider requested affirmation noting that prior PRRB decisions support this current decision.

DISCUSSION AND EVALUATION

The entire record which was furnished by the Provider Reimbursement Review Board has been examined, including the transcript of the oral testimony before the PRRB, all correspondence, position papers, exhibits, and the parties' post-hearing briefs. The PRRB's decision has been reviewed by the Administrator. All comments received after entry of the PRRB's decision have been made a part of the record and have been considered.

Issue No. 1

The underlying facts of this case are not in dispute. The Provider borrowed approximately $7.6 million in 1972, and $10.4 million in 1982, through the issuance of bonds, to finance various capital projects. The interest rate on the bonds varied at approximately 5.25 to 7% on the 1972 bonds and 12 to 12.5% on the 1982 bonds. On February 1, 1985, the Provider refinanced the bonds with a new issuance at rates varying from 6.5 to 10.5%. All of the funds were then turned over to a trustee who became responsible for payment of the refunded debt. As a result of this transaction, the Provider expects to save approximately $12 million in interest expense over the remaining term of the 1985 bonds.

The Provider calculated a loss of $672,581 on the refunding of the 1972 and 1982 bonds in accordance with APB Opinion No. 26, "Early Extinguishment of Debt." The Provider has claimed the entire loss in its cost reporting period ending December 31, 1985. The loss is attributable to unamortized bond issue and discount costs on the refunded bonds, the difference between investment income earned by the trustee and interest expense on the refunded bonds, and a call premium on the 1982 bonds.

Under § 1814(b) of the Social Security Act [42 USC 1395f(b)], providers of health care services to Medicare beneficiaries are entitled to be reimbursed for the "reasonable cost" of the capital-related component of providing such services.[3] "Reasonable cost" is de-

[3] The loss claimed by the Provider in this case is a capital-related cost, which is reimbursed in the same manner under the Prospective Payment System, which became effective in 1984, as it was under the cost-based system.

fined in the Social Security Act as "the cost actually incurred . . . and . . . determined in accordance with the regulations."[4] Those regulations must "consider, among other things, the principles generally applied by national organizations or established prepayment organizations (which have developed such principles) in computing the amount of payment." One overriding requirement of the legislation and related regulations is that "the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this title will not be borne by individuals not so covered, and the cost with respect to individuals not so covered will not be borne by such insurance programs."[5]

When the Medicare regulations do not specifically address the method of calculating a particular cost, GAAP will usually provide a reasonably accurate calculation of the cost of delivering health services to a provider's patients. GAAP consists of the official publications of the American Institute of Certified Public Accountants (AICPA). These official publications consist of Accounting Principles Board (APB) opinions, Financial Accounting Standards Board (FASB) statements, and Accounting Research bulletins (ARB). Where there is no official pronouncement, the consensus of the accounting profession, as manifested in textbooks, determines GAAP.[6]

While GAAP can be useful in determining costs related to patient care, they are not necessarily con-

[4] § 1861(v)(1)(A) of the Act [42 USC 1395x].

[5] *Id.*

[6] *HCA Health Services of Midwest, Inc. v. Bowen*, 869 F.2d 1179, 1181, n.3 (9th Cir. 1989).

trolling. § 1861(v)(1)(A) of the Act only required the Secretary to "consider . . . the principles generally applied by national organizations;" the Secretary is not required to adopt them for determining reimbursable cost.[7] Neither Congress nor the Secretary abdicated to the accounting profession the responsibility for determining Medicare reimbursement policy.

When evaluating whether it is appropriate to use GAAP for calculating Medicare reimbursement, one must first consider whether Medicare has a specific policy in effect. If Medicare does not, one must determine whether GAAP will identify costs that are in economic reality borne by the provider, and if so, whether the cost is properly related in time to care being rendered to Medicare beneficiaries.[8]

The Administrator finds that for the Provider's fiscal year under review, Medicare did have a specific policy in effect governing the treatment of refunding transactions. That policy, found in § 233 of the Provider Reimbursement Manual, is consistent with the preferred method under ARB No. 43. § 233 was published in May 1983, and was effective for all cost

[7] *Spartanburg General Hospital v. Heckler*, 607 F. Supp. 635, 641 (D.S.C. 1985). *Cf. Sun Towers, Inc. v. Heckler*, 725 F.2d 314, 328-9 (5th Cir. 1984); *American Medical International, Inc. v. Secretary*, 466 F.Supp. 605, 624 n.21 (D.D.C. 1979), aff'd, 677 F.2d 118 (D.C. Cir. 1981).

[8] *Humana, Inc. v. Heckler*, 758 F.2d 696, 705, n.68 (D.C. Cir. 1985). See also, *Doctors Hospital v. Califano*, 459 F. Supp. 201, 208-210 (D.D.C. 1978), affirming a PRRB decision disallowing a "loss" on the demolition of two buildings despite a regulation apparently allowing the loss, because the "economic realities of the transaction" were to increase the value of the underlying land more than the remaining value in the buildings.

reporting periods beginning on or after July 1, 1983. The refinancing at issue here occurred February 1, 1985.

The effect of § 233 is to require the loss on a refunding to be amortized over a number of years. This section is interpretive of 42 CFR 405.451, "Cost Related to Patient Care"[9] which requires payments to be based on "the actual cost of services rendered to beneficiaries during the year." This policy more accurately reflects the economic reality of a bond refunding on the cost of furnishing services to Medicare beneficiaries than does APB No. 26.

§ 233 superseded § 215 of the Manual, and expressly applied to advance refunding of debt. It requires any gain or loss on the transaction to be amortized from the date of the refunding transaction to when the refunded bond principal is paid. This section was a clarification rather than a change of policy.[10]

The economic realities of the case at hand demonstrate the superiority of amortizing the loss on defeasance, rather than allowing the full cost in the year of refinancing. While the Provider's obligation on the original bond issue to repay principal of approximately $15.6 million increased slightly with the refinancing, the overall interest obligation over the remaining term of the borrowing would decrease substantially. Since Medicare would recognize interest, which is the cost incurred for the use of borrowed funds,[11] as an allowable cost in the years when ac-

[9] Recodified at 42 CFR 413.9.

[10] § 233.1, PRM Transmittal No. 288, May 1983.

[11] 42 CFR 413.153.

crued, this would represent a substantial saving to both the Provider and the program. This savings would be spread over the years from 1985, when the refinancing occurred, until 2003, when the refunding bonds would be paid. The Provider estimated the net present saving to be approximately $12 million.

Medicare does not reimburse principal as such. The repayment of principal is not a cost; it is merely using an asset (cash) to cancel a liability of equal value. Medicare does, however, reimburse providers for Medicare's share of the cost of a capital asset, related to patient care, which was purchased with borrowed money. For example, Medicare will recognize as an allowable cost depreciation on a building constructed with borrowed money.[12] In this way, the principal amount is reimbursed.

Although the Provider improved its financial outlook, APB No. 26 advised it to recognize a loss on the refunding, because the APB limited its concern to the treatment of the principal obligation. This may be prudent for financial reporting, because the Provider's net worth was immediately reduced because of the increased principal obligation, but the full reduction of the interest obligation will not be enjoyed until future periods.

However, this loss is not a cost of providing health care services to Medicare beneficiaries in the year of the refunding. The loss was merely an adjustment to the Provider's capital structure which enabled the Provider to substitute less expensive financing for its existing more expensive financing. Thus, the loss on

[12] 42 CFR 413.134.

the refinancing did not relate exclusively to patient care services rendered in the year of the loss. The loss is more closely related to the years over which the original bond term extended (the period over which the lower interest will be enjoyed) than to the year in which the refunding occurred.

The Administrator notes that this loss is reported on the provider's financial statements as an extraordinary item, separate and apart from the "Operating Expenses." The loss is related to patient services expected to be rendered over the unexpired term of the defeased bond issuance, when the lower interest rates are being enjoyed. This is further evidence that the loss is not a current period cost.

Accordingly, the Administrator finds that the loss is a cost of rendering patient care over several years. By amortizing the loss to match it to Medicare utilization over the years to which it relates, the program is protected from any drop in Medicare utilization, and the provider is likewise assured that it will be adequately reimbursed if Medicare utilization increases.[13] Further, the program is protected from making a payment attributable to future years and then having the provider drop out of the Program before services are rendered to Medicare beneficiaries in those future years.

[13] Similarly, the court in *Spartanburg General Hospital v. Heckler*, 607 F.Supp. 635, 646 (D.S.C. 1985), held: "Capitalization [of certain planning costs] will result in the costs being reimbursed both at the time Medicare patients actually use the building and commensurate with the changing levels of Medicare utilization over the years. The court defers to the Secretary's policy choice, cognizant of her responsibilities as the steward of a public trust."

The statutory prohibition against cross-subsidization [14] requires that costs recognized in one year, but attributable to health services rendered over a number of years, be amortized and reimbursed during those years when Medicare beneficiaries use those services. The U.S. Court of Appeals for the Eighth Circuit used similar reasoning in *Research Medical Center v. Schweiker*, upholding the Secretary's requirement that construction interest be capitalized. The Court wrote:

> "The capitalization requirement of Sec. 206 of the Provider Reimbursement Manual attempts to implement the statutory requirement that Medicare costs should not be borne by non-Medicare patients. Capitalization allows the Medicare reimbursement to change as the percentage of Medicare patients in a medical facility changes over the years. . . . If the interest expense were currently reimbursed, and [the provider] withdrew from the Medicare program shortly after the construction was completed, [the provider's] non-Medicare patients would benefit for many years from a Medicare reimbursement." [15]

Likewise, in *Gosman v. United States*,[16] the Court of Claims declined to use GAAP in favor of a Provider Reimbursement Manual section which required the cost of securing mortgage financing to be amortized and reimbursed over the life of the mortgage.

---

[14] Note 4, supra.

[15] 684 F.2d 599, 603 (8th Cir. 1982).

[16] 573 F.2d 31, supra note 8.

The Administrator notes that the Provider was not required by the refinancing to make any immediate out-of-pocket payment to satisfy the refinancing loss. Instead, the loss was absorbed by the greater amount borrowed under the 1985 series of bonds. Thus, the Provider has not actually experienced an immediate unreimbursed outflow of funds. Reimbursement of the loss over a period of years, therefore, will more accurately allocate the Provider's refinancing costs, and at the same time, more accurately reflect its current period costs.

Accordingly, the Administrator hereby holds that § 233 of the Manual is applicable to the Provider's bond refunding transaction. The effect is to amortize the loss on the advance refunding over those periods which benefit from the reduced interest rate.

Issue No. 2

The facts in this issue are also clear and undisputed. As part of its 1985 bond refinancing, the Provider was required to establish two debt service accounts with the trustee: one for payment of principal on the refunding bonds, and the other for the payment of interest. The Provider contributed to these accounts with funds from operations. The trustee then disbursed the funds as required.

Under 42 CFR 413.153(a)(1), necessary and proper interest expense is an allowable Medicare cost. In defining "necessary," 42 CFR 413.153(b)(2)(iii), requires that interest be reduced by investment income except when it is from funded depreciation or a qualified pension fund. Funding depreciation is authorized under 42 CFR 413.134(e) and § 226 of

the Manual, and is the setting aside of funds for the acquisition of depreciable assets or other capital expenditures related to patient care. In describing other capital purposes, § 226 states "Other capital purposes include capital debt liquidation, such as *principal* payments for bonds and mortgages and nonborrowed bond reserve and sinking funds to the extent used for a capital purpose . . ." [emph. added]

In this case, there were two bond reserve accounts: one for payment of principal and the other for payment of interest. There is no dispute that the account for payment of principal qualifies as a funded depreciation account and no offset is required. However, the funds set aside for payment of interest do not qualify as funded depreciation because they are not being used for a capital purpose. Interest is not a capital cost; it is a current period operating expense. It is apparent from § 226 of the Manual, that Medicare does not recognize interest as a capital cost, and, therefore, funds set aside to pay interest do not qualify as funded depreciation.

The Administrator notes that the *Good Samaritan* [17] case, referenced by the Provider, does allow a bond fund that will pay interest to be recognized as a funded depreciation account. However, in that case the reserve fund was established to pay both principal and interest, without any distinction of funds within the account. In the current case, two separate funds were created for the separate paying of prin-

[17] *Good Samaritan Hospital v. Blue Cross Association/Mutual Hospital Insurance, Inc.*, PRRB Decision No. 79-D80 (Nov. 26, 1979), aff'd HCFA Admin. Decision (Jan. 23, 1980).

cipal and interest, respectively. Further, the Administrator stated in *Good Samaritan* that in the event the funds set aside to pay interest could be identified, those amounts would not qualify as funded depreciation and offset would be required. Accordingly, the investment income earned in the debt service fund must reduce allowable interest expense.

DECISION

The decision of the Provider Reimbursement Review Board is reversed on both issues. The Provider must amortize the loss on the early refunding of the 1972 and 1982 bond issuances in accordance with § 233 of the Provider Reimbursement Manual (HIM-15). Also, the Provider must offset investment income earned in the debt service fund designated to pay interest against allowable interest expense.

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES

Date: 10-12-90

/s/ J. Michael Hudson
J. MICHAEL HUDSON
Deputy Administrator
Health Care Financing Administration

APPENDIX E

Provider Reimbursement Review Board
Hearing Decision

90-D50

Date of Hearing—August 22, 1989

PROVIDER—GUERNSEY MEMORIAL HOSPITAL
CAMBRIDGE, OHIO
Provider No. 36-0203

vs

INTERMEDIARY—BLUE CROSS AND BLUE SHIELD ASSOCIATION/COMMUNITY MUTUAL INSURANCE COMPANY

Cost Reporting Period Ended—December 31, 1985

Case No. 88-1092

INDEX

ISSUES:

1. Whether the Intermediary's adjustment disallowing a portion of the Provider's loss on the advance refunding of debt is correct?
2. Whether the Intermediary's adjustment offsetting a portion of the income earned by the Debt Service Fund because the Fund was deemed as not used for capital purposes is correct?

SUMMARY OF FACTS:

The Provider is a general, short-term, acute care hospital located in Cambridge Ohio. The Intermediary issued a Notices of Program Reimbursement (NPR) on November 30, 1987, for calendar year 1985 which included audit adjustments relating to the above issues. The Provider filed a request for hearing with the Provider Reimbursement Review Board (Board) pursuant to 42 CFR 405.1835ff and has met the jurisdictional requirements of those regulations. Both issues result in a reduction in Medicare reimbursement of approximately $326,000.

Issue No. 1—Loss on Bond Advance Refunding

Prior to February 1, 1985, the Provider was obligated to pay debt service costs on bonds issued in 1972 and 1982 to fund certain hospital improvements which were related to patient care. The original principal amounts of these bonds were $7,600,000 and $10,410,000 in 1972 and 1982, respectively. The 1972 bonds had interest rates ranging from 5.25% to 7% and were scheduled to be paid off by December 1, 1986. The 1982 bonds had interest rates rang-

ing from 12% to 12.5% and were scheduled to paid off in 2012. The 1982 bonds also had an option for recall (call date) of 1992.

The Provider decided to advance refund both of those bonds issues by issuing $15,375,000 Hospital Improvement Revenue Refunding Bonds, Series 1985 (refunding bonds). On February 1, 1985, the City of Cambridge Ohio (the City) and the BancOhio National Bank (Trustee) executed a trust indenture issuing the 1985 refunding bonds on behalf of the Provider. These bonds had interest rates ranged from 6.5% to 10.5% with approximately two-thirds of the 1985 refunding bonds carrying the 10.5% rate. In turn, the Provider deeded its hospital facilities to the City which then leased the same back to the Provider. The proceeds of the 1985 refunding bonds together with the remaining sums in various restricted funds created by the earlier bond issuances amounted to $16,011,200. Those funds were deposited into an irrevocable escrow account maintained by the Trustee. The Trustee was responsible for paying the interest and principal on the refunded 1972 and 1982 bonds. On February 27, 1985, the City, Trustee, and the Provider executed a release whereby the Provider was discharged from any further obligations regarding the refunded bonds.

As a result of this advance refunding the Provider incurred and claimed on its cost report an extraordinary loss of $672,581 calculated as follows:

NET REACQUISITION PRICE:	
Purchase of escrow securities	$16,011,200
NET CARRYING AMOUNT OF OLD DEBT:	
Old debt:	
1982 Bonds outstanding	$10,410,000
1972 Bonds outstanding	5,220,000
Unamortized financing cost	(709,499)
Interest expense payable	418,118
NET CARRYING AMOUNT OF OLD DEBT	$15,338,619
LOSS ON ADVANCE REFUNDING OF DEBT	$ 672,581

The Intermediary disallowed the entire loss claimed by the Provider which resulted in a reduction in Medicare reimbursement of approximately $314,000.

Provider's Contentions:

The Provider contends that various Medicare regulations support the recognition of the loss on the advanced refunding of the 1972 and 1982 bonds. 42 CFR 405.402(a) requires that payments for costs be made on a current basis. 42 CFR 405.452(a) requires that reimbursement be made on accrual accounting principles, and that expenses be reported in the period in which they are incurred regardless of when they are paid. The Intermediary's recognition and amortization of the loss over the life of the refinancing bonds conflicts with the latter regulation. 42 CFR 405.406(a) which requires standardized definitions, accounting, statistics and reporting practices which are widely accepted in the hospital and related fields has been met. The Provider used Generally Accepted Accounting Principles (GAAP) to arrive at this loss. Specifically, it used Accounting

Principle Board (APB) No. 26 and Financial Accounting Standard (FAS) No. 76.

The Provider compiled with the reasonable cost requirements of 42 CFR 405.451. By advance refunding the 1972 and 1982 bonds, the Provider has demonstrated that it would save approximately $12 million in debt service costs due to the lower interest rate and shorter life of the 1985 refunding bonds. The issuance of the 1985 refunding bonds also eliminated several restrictive covenants present in the 1972 and 1982 bond indentures. That allowed the Provider the ability to incur additional debt at a lower interest rate and released capital to purchase additional patient care facilities (TR 36, 37).

Provider Reimbursement Manual (PRM) section 233 which the Intermediary used to disallow the loss on the advance refunding of the 1972 and 1982 bonds is contrary to the above regulations as well as GAAP and case precedent. Both parties have stipulated that the Intermediary's treatment of the Provider's loss did not comply with GAAP (Provider Exhibit 35). Moreover, the PRM section is illogical. It is forcing a loss recognition into the future for something that had happened previously which the Provider cannot reverse in the future (TR 160, 161). The Intermediary's application of PRM section 233.3 is not based on actual costs. Its combining the debt service costs of the refunded and refunding bonds and offsetting them by the investment income earned by the Trustee's escrow account does not properly measure the Provider's costs. Further, the Intermediary's witness testified that the interest expenses on the refunded bonds was a cost of the Trustee and not the Provider's cost (TR 198, 199). PRM section 233.3 is in-

ternally inconsistent. The Intermediary admitted that had the Provider sought to call the refunded bonds in 1985, which would have been more costly than placing the proceeds of the refunding bonds in escrow, the Intermediary would have allowed the refinancing loss in full in 1985.

GAAP should be used in this case and is supported by case law. In *Ravenswood Hospital Medical Center v. Schweiker*, 622 F. Supp. 338 (N.D. Ill 1987), the District Court supported the Board's decision that the Provider was entitled to take the full loss on early debt extinguishment in the year incurred. GAAP supports this treatment. In *Charlotte Memorial Hospital and Medicare Center, Inc. v. Bowen*, U.S. Ct. of Appeals, Fourth Cir., No. 87-3745 (September 1988), the Circuit Court rejected both a PRM section and an Intermediary Letter because they both conflicted with GAAP. Because of that conflict, the Court found that the Medicare Program's instructions cut against the very tenor of 42 CFR 405.453. In *Hollywood Presbyterian Hospital—Olmstead Memorial v. Bowen*, CV 87-2595 (C.D. Cal. September 2, 1988), the District Court struck down a PRM section which was inconsistent with GAAP. In *National Medical Enterprise v. Bowen*, U.S. Ct. of Appeals, Ninth Circuit, No. 87-5605 (July 1988), the Circuit Court pointed out that a regulation has the force of law; therefore, an agency's interpretation of a statute in a manner inconsistent with the regulation will not be enforced. Based on these decisions, GAAP, and not PRM section 233, should be applied to this situation. Moreover, Board decision 89-D65, dated September 26, 1989, *Baptist Hospitals Group*, controls this case. The facts are essentially the same as the Provider's.

Intermediary Contentions:

The Intermediary contends that various Medicare regulations prohibit the Provider from claiming the loss on the advance refunding of its 1972 and 1982 bonds. 42 CFR 405.451 is the primary regulation that supports its position. The loss is not a reasonable cost related to patient care in 1985, the year of the advance refunding. A loss is not a cost. In this case, the loss results from the substitution of one debt for another. For a cost to be allowed, paying cash or incurring a liability in exchange for goods or services that enhance patient care must occur. This loss does not meet that reasonable cost requirement. Moreover, when the individual elements of the loss are identified, they do not meet the reasonable cost requirements in 1985. The elements of the loss consist of: (1) unamortized bond issue and discount costs on the refunded bonds; (2) the call premium on the 1982 bonds; and (3) the difference between the investment income earned by the trustee and the interest expense on the refunded bonds. None of those elements related to patient care in 1985.

The accrual acounting requirement of 42 CFR 405.453 is not violated by the Intermediary's rejection of the Provider's total loss in 1985. The key term in this regulation is *expense*. The Provider is arguing that since it chose APB No. 26's current income statement recognition of a loss over a deferred recognition, this turns the loss into an expense. The Intermediary disagrees. Further, 42 CFR 405.419 does not allow as interest expense an amount needed to fund a trusteed required escrow account larger than the 1972 and 1982 bonds balance and unamortized finance costs.

PRM section 233 should be applied in this case. The objective of that section i.e., to recognize any gain or loss incurred as a result of an advance refunding from the date the refunding debt is issued to the date the bondholders receive the refunding debt principal rather than an immediate loss recognition, is consistent with 42 CFR 405.451. This treatment of the loss is consistent with the nature of the financing transaction, i.e., to pay for the debt over some specified future period. That matches Medicare utilization with the payment of the refunding debt. It protects the Medicare program by not making payments for future periods in a current cost reporting period. It protects Medicare from paying excessive amounts currently because providers may terminate from the Medicare program or have significantly reduced Medicare utilization in future years when the refunding bonds are being paid-off. Further, although PRM section 233 treats the loss on the advance refunding differently than GAAP, it is only one of several PRM sections that do so. The reason for this is that GAAP is concerned with providing a consistent reporting of a financial position for investors and management. On the other hand, the Medical program instructions are concerned with determining reasonable costs of providing services to Medicare beneficiaries.

Various subsections of PRM 233 properly treat the various elements of the refunding bonds. PRM section 233.3 would allow the call premium, if exercised, in 1992. That is the year it would be paid. At the time of the refinancing, unamortized discounts and debt issue costs remained. PRM section 233.3(c) properly amortizes bond issuance costs over the period

from the issue date of the refinancing bonds to the date the bondholders will receive the principal amount. PRM section 233.3(d) allows interest when paid or accrued by either the Provider or Trustee on an annual basis.

When APB No. 26 was issued, there was a clear disagreement on how losses on advance refunding should be treated. As noted in discussion point 5. in APB No. 26:

> "5. Differences on non-refunding extinguishments are generally treated currently in income as losses or gains. Three basic methods are generally accepted to account for the differences on refunding transactions:
>
> a. Amortization over the remaining original life of the extinguished issue
>
> b. Amortization over the life of the new issue
>
> c. Recognition currently in income as a loss or gain."

Each method has been supported in court decisions, in rulings of regulatory agencies, and in accounting literature.

PRM Section 233 comes closest to using approach a. above. However, instead of using the original life of the bond issue that was refinanced, PRM Section 233 uses the expected pay-off of the refunded bonds as the end of the period of amortization. This make sense since the identification of the most financially advantageous point to have the Trustee pay off the old debt is an integral part of structuring the refinancing and determining the exact amount that is

needed to effect the refinancing. Therefore, the considerations in support of option a. would be valid in analyzing PRM Section 233 and in determining which option best complies with the reimbursement requirement expressed in Regulation 42 CFR 405.419.

Various Court and Board decisions support the Intermediary's position, refute the Provider's position, or are not relative to this case. The *Methodist Hospital of Indiana, Inc. v. U.S. Inc. v. Heckler*, 725 F.2d 314, and *Sun Towers American Medical International v. Secretary of H.E.W.* 466 F. Supp. 605 support the Intermediary's position on the role of accrual accounting in determining reasonable costs. In the *Ravenswood Hospital Medical Center v. Schweiker* [*sic*], USDC, Northern District of Illinois, No. 82C4872, May 8, 1985, the Court ruled that a refinancing loss was fully allowable. However, the major element of that cost was a call premium, and it was paid. In this case the call premium cannot be paid until 1992. Also, in the latter decision, the court was concerned with the different treatment of gains as compared to losses. PRM section 233 treats gains and losses similarly. In *Charlotte Memorial Hospital and Mechanical Center, Inc. v. Bowen*, U.S. Court of Appeals, 4th Cir. No. 87-3745 (September 1988), the decision cited by the Provider, the Circuit Court dealt with a totally different factual issue, i.e., deferred compensation. Further, it did not rule out the Medicare program's overruling GAAP. In this case, the Intermediary requests the Board to address the court's challenge of scrutininzing the type of cost at issue. A loss of an advance refunding should result in a departure from GAAP because GAAP does not accurately reflect the cost of patient care. GAAP

recognizes the cost of running a business. Moreover, the advance refunding only results in a modest cost outlay change. Interest and bond issue amortization on the "old" bonds was $1,472,241. Interest on the "new" bonds was $1,471,717. Nevertheless, the Provider wants to be reimbursed on the basis of $2,144,298 of debt. The only "out-of-pocket" expenses incurred by the Provider were the costs of the bond issuances, and those were on the 1972 and 1982 bonds.

Board decision 89-D65, dated September 26, 1989, *Baptist Hospitals Group*, has not been reviewed by the Health Care Financing Administration (HCFA) Administrator. On the other hand, the Board decision 83-D54, dated April 29, 1983, *Shawned Mission Medical Center* has been, and it clearly focuses on the true nature of the loss from an advance refunding. The latter is a better reasoned case.

The Provider contends that reimbursement for advance refunding losses should be treated the same as a disposal of a capital asset. There are major conceptual differences between these two concepts such as:

OUTRIGHT SALE OF FIXED ASSET	LOSS ON REFINANCING
1. Asset removed from books.	1. Liability removed from books.
2. Removal of asset alone.	2. Removal of liability alone yields a gain. The loss occurs because you replace it with a different liability. There is no loss if you do not borrow more money—this is the sole reason for the loss. The loss doesn't occur because you dispose of a liability.
3. Recognizing the loss in the the current year just lets you recover the entire expenditure you made now that the asset is gone.	3. The asset is not gone. It has just cost you more now that you have increased borrowing. This should appropriately be spread over a period of years.
4. The loss resulted because no purchase would pay the owner net book value. (A negative event).	

Issue No. 2—Investment Income Offset

As part of the above refunding bond transaction, Article 5 of the Trust Indenture establishes a debt service fund (DSF) for the payment of principal and interest due on the refunding bonds. Pursuant to the provisions of that article, the Trustee, besides controlling the escrow account which was created by the sale of the refunding bonds and will be used to pay off the refunded bonds, maintains custody of the DSF on the refunding bonds. It made periodic deposits into the DSF and was also permitted to make certain investments of sums into same. Any income earned by the DSF was credited to the fund unless there is a need to meet minimum balance requirements of other special funds created by the Trust Indenture. The lease component of the Official Statement relating to the Original Issuance of $15,375,000 City of Cambridge Ohio Hospital Improvement Revenue Refunding Bonds, Series 1985 (Page 27 of Intermediary Exhibit A) required that a separate interest payment account and principal payment account of the DSF be established. The funds in the interest payment account were used to pay semi-annual interest payable on the 1985 bonds.

Between February 1 and December 31, 1985, the interest account of the DSF earned $24,874. The Pro-

vider did not offset that interest income earned against its allowable interest expense. The Intermediary did, and this resulted in a reduction in Medicare reimbursement of approximately $12,000.

Provider's Contentions:

The Provider contends that various Medicare regulations support its position that it was unneecssary to offset investment income against allowable interest expenses when the investment income was earned by a funded depreciation account established for a capital purpose. 42 CFR 405.419(c)(3) requires that if funded depreciation is used for purposes other than improvements, replacement or expansion of facilities or equipment, an offset of investment income earned must be made. The Provider's witness stated in his affidavit that:

1. The DSF serves a capital-related purpose.
2. The payment of principal and interest due on the refunding bonds from sums in the DSF is a capital-related cost of the Provider.
3. The DSF is an integral component of the Provider's 1985 advance refunding of capital indebtedness. In fact, the issuance of the refunding bonds probably would have been impossible without the creation of the DSF.
4. The DSF constitutes a qualified funded depreciation account under Medicare laws and interpretations.
5. Any investment income earned on the DSF should not be offset against the Provider's allowable interest expense.

42 CFR 405.415(e) encourages providers to fund depreciation. The Provider's establishment of the various reserve funds, including the interest and principal fund, responds to this regulatory encouragement.

Board decision 83-D89, dated June 8, 1983, *Medical Center Hospital*, held that investment income earned on a bond restricted sinking fund used for the payment of principal and interest is not properly offset against a provider's allowable interest expense. This was affirmed by the HCFA Deputy Administrator's July 28, 1983 decision. In this case, the DSF has a capital related purpose and, as such, constitutes funded depreciation.

The fact that one portion of the fund may be used to pay principal and the other interest does not change the resulting purpose.

Intermediary Contentions:

The Intermediary contends that 42 CFR 405.419(b)(2) and PRM 226 requires an investment income offset in this case. The interest payment account does not qualify as funded depreciation under the above Medicare regulation and program instruction because the purpose for which the fund was established, i.e., payment of interest expense, is not a valid capital-related purpose. It is an operating expense. Interest expense can qualify as capital-related and be reimbursed on a cost basis under Medicare's Prospective Payment System (PPS). However, the capital-related purpose of PPS is not the same as "capital purposes" stated in PRM section 226.

In its position paper, the Provider referred to Board decision 83-D89, dated June 8, 1989, *Medical Center Hospital*, as it relates to this issue. That decision

references Board decision 83-D46, date June 15, 1984, *Medical Center Hospital,* which in turn references Board decision 79-D31, dated May 31, 1979, *Humana Inc. Group Appeal.* The last decision held:

> "The Board finds that evidence clearly demonstrates that the Renewal and Replacement Funds, Bond Security Funds and Reserve Funds in reality are funded depreciation and meet the requirements as set forth in section 226 (HIM-15). On the other hand, with respect to interest accounts maintained under the Colonial Manor Hospital Bond Issue and the Shoals Hospital Bond Issue, and the Insurance Fund maintained under the Medical Center Hospital Bond Issue, the Board finds these are not funds that are restricted for capital purposes; therefore, should not be treated as funded depreciation."
>
> The Provider's analysis of that case actually supports the Intermediary's adjustment.

CITATION OF APPLICABLE LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. *Law-Title XVIII of the Social Security Act:*
   1861(v)(1)(A) — Reasonable Cost
2. *Regulations—42 CFR 405, Subpart D:*
   a. Section 405.406 — Financial Data and Reports
      (Redesignated Section 413.20)
   b. Section 405.451 — Cost Related to Patient Care
      (Redesignated Section 413.9)
   c. Section 405.453 — Adequate Cost Data and Cost Finding
      (Redesignated Section 413.24)
   d. Section 405.419(b)(2) — Necessary
      (Redesignated Section 413.153(b)(2))
3. *Program Instructions Provider Reimbursement Manual (HCFA Pub. 15-1):*
   Section 226 — Funded Depreciation

FINDINGS AND CONCLUSIONS:

Issue No. 1—Loss on Bond Advance Refunding

The Board, after considering the facts, the parties' position papers, evidence presented the testimony at the hearing, and post-hearing briefs, finds that the Provider is entitled to take the full loss on the advance refunding of the Series 1982 bonds in FY 85. The Board finds that the loss on defeasance is an allowable cost under 42 CFR 405.451 and is to be reimbursed in its entirety in the fiscal year at issue. Under GAAP, the loss on defeasance was a cost incurred in FY 85. This accounting treatment conforms with the requirements found in: (1) 42 CFR 405.406 —providers are to follow standardized accounting practices; and (2) 42 CFR 405.453—providers are to furnish adequate cost data based on the accrual method of accounting.

Section 405.451 of Volume 42 of the Code of Federal Regulations requires that all payments to providers of services must be based on the reasonable cost of services and related to the care of beneficiaries. Reasonable cost includes all necessary and proper costs incurred in rendering the services. As provided by 42 CFR 405.451, necessary and proper costs are costs which are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities and are usually costs which are common and accepted occurrences in the field of the providers' activity. The Board holds that the Providers has submitted substantial evidence that the loss on defeasance meets these criteria, i.e., that it was reasonable, related to patient care, a necessary and proper cost, and a common and accepted occurrence in bond financing in the hospital industry.

The crux of the Intermediary's argument was that because there is nothing in the Medicare regulations that identifies a loss on extinguishment of debt as an allowable cost, the Intermediary must first analyze the "loss" against 42 CFR 405.451 to determine if it is allowable. PRM section 233, also used by the Intermediary to disallow the loss, breaks down the loss into components and presents individual reimbursement treatments for each component. The Intermediary broke the loss into the following components: call premium, unamortized discount, unamortized issue, and interest expenses. The Intermediary further argued that the Provider's use of GAAP would turn a claimed cost—which it determined to be non-allowable because it does not fall under any of the general or specific categories of allowable cost—into a reimbursable cost just because it may be permissible under GAAP to reflect the item in a provider's financial statements. In other words, Medicare reimbursed providers for specific cost items, not anything that appears as a debit entry on a provider's income statement.

The Board rejects these Intermediary arguments and stresses that it is not turning an unallowable cost into a reimbursable cost solely because it is permissible under GAAP to reflect the loss in the Provider's financial statement. The Board emphasizes that it accepts the Provider's treatment because it believes that the cost, as incurred, is allowable under 42 CFR 405.451 —the cost was reasonable, necessary and proper, and related to patient care.

In this case there was no allegation by the Intermediary that the refinancing was not prudent. Therefore, the cost was reasonable as required by 42 CFR

405.451(b)(1). In addition, the refinancing costs were appropriate and helpful in maintaining the operation of patient care facilities and activities. Once the Provider decided that the refinancing decision was prudent, they had very little flexibility regarding the methodology of refinancing. The methodology and attendance costs are common and accepted occurrences in the field of the Providers' activity. Hence, the refinancing costs were necessary and proper costs as defined in 42 CFR 405.451(b)(2).

The loss was related to patient care in 1985, the year of defeasance. The Board finds that the loss resulted from a change in the current market value of the debt. Market value of debt is determined by the market rate of interest. Had the market value of the debt been recorded in the Provider's books as the market rate of interest fluctuated, the changes in the market value of the debt would have been recorded periodically as losses or gains. There would have been no loss on the extinguishment of the debt. For that reason, the entire loss or defeasance should be recorded when the bond contract is terminated, because it relates to the past periods when the bond contract was in effect.

Stated differently, if, when the bonds were issued, it had been known that they would be defeased in 1985, the annual cost associated with those bonds, i.e., interest and bond discount and call premium amortization, would have been adjusted so that the maturity value of the debt would equal the reacquisition price. Thus, no difference upon early extinguishment would have occurred because previous periods would have borne the proper interest expense. This rationale is also supported by GAAP, as outlined in Accounting Prin-

ciples Board Opinion No. 26 on early extinguishment of debt.

This treatment is similar to that which occurs when a fixed asset is disposed of and replaced before the end of its estimated useful life. Any loss on disposal is clearly related to the old asset and not the replacement. The loss results from the fact that the actual depreciation in value of the asset differs from that recorded on the books. For that reason, the loss on disposal is treated as an allowable cost in the year of disposal. Likewise, the loss on defeasance should be treated as an allowable cost in the year of defeasance.

The PRRB recognizes that the Administrator has reversed the Board on this same issue in two prior cases. These are *Baptist Hospitals Group v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Kentucky, Inc.*, HCFA Administrator Decision, Nov. 22, 1989, CCH Medicare and Medicaid Guide (hereinafter CCH), para. 38,308; and *Mercy Hospital v. Blue Cross and Blue Shield*, HCFA Administrator Decision, Nov. 22, 1989, CCH para. 38,307.

In both cases the Administrator discussed the Supreme Court's analysis of the role of GAAP in the income tax system in *Thor Power Tool Company v. Commissioner of Internal Revenue* 439 U.S. 522 (1979) and expressed the opinion that the analysis was applicable to the Medicare cost system. The aspect of *Thor* relied upon by the Administrator was the Court's discussion of the differences in the primary goal of financial accounting and that of the income tax system, and the Court's opinion that, given the diversity of objectives, any presumption of equiva-

lency between tax and financial accounting would be unacceptable.

Essentially, however, the Court's discussion of the differing goals—policy objectives as it were—between the two systems of accounting is but the last leg of the Court's decision that the Commissioner was correct in his decision that the taxpayers write-down of "excess" inventory failed to reflect income clearly even though the write-down conformed to generally accepted accounting principles. The general policy discussion was preceded by a detailed analysis of the governing regulations. In these regulations the Supreme Court found clear authority for the Commissioner to reject any method of accounting unless in the opinion of the Commissioner it clearly reflected income.

One of the governing regulations in *Thor* had provided that "[a] method of accounting which reflects the consistent application of generally accepted accounting principles . . . *will ordinarily be regarded* as clearly reflecting income." Emphasis added. This same regulation also provided that "*no method of accounting is acceptable unless, in the opinion of the Commissioner, it clearly reflects income.*" Emphasis added. Yet another governing regulation provided that an inventory taken in conformity with best accounting practice "can, *as a general rule*, be regarded as clearly reflecting . . . income." Emphasis added. The Plaintiff argued that these regulations created a *presumption* that accounting for inventory in accordance with generally accepted accounting principles was valid for income tax purposes. The Plaintiff then argued that as long as the taxpayer used generally accepted accounting principles, the burden shifted to the Commissioner to demonstrate that taxpayers

method did not reflect income clearly. The Court rejected this position and stated in part:

> We believe . . . that no such presumption is present. Its existence is insupportable in light of the statute, the Court's past decisions, and the differing objectives of tax and financial accounting.
>
> First, as has been stated above, the Code and Regulations establish two distinct tests to which an inventory must conform. The Code and Regulations, moreover, leave little doubt as to which test is paramount. While Section 471 of the Code requires only that an accounting practice conform "as nearly as may be" to best accounting practice, Section 1.446-1(a)(2) of the Regulations states categorically that "*no* method of accounting is acceptable unless, in the opinion of the Commissioner, it clear reflects income" (emphasis added). Most importantly, the Code and Regulations give the *Commissioner broad discretion to set aside* the taxpayer's method if, "in [his] opinion," it does not reflect income clearly. This language is completely at odds with the notion of a "presumption" in the taxpayer's favor. The Regulations embody no presumption; they say merely that, in most cases, generally accepted accounting practices will pass muster for tax purposes. And in most cases they will. *But if the Commissioner, in the exercise of his discretion, determines that they do not, he may prescribe a different practice without having to rebut* any presumption running against the Treasury. *Thor* 439 U.S. at 785. Emphasis added.

In contrast to the tax code, the Medicare regulations, principally 42 CFR 405.406, do not appear to provide authority for the Administrator to reject the use of GAAP to determine actual cost. Section 405.406 provides that:

> The principles of cost reimbursement will require that providers maintain sufficient financial records and statistical data for proper determination of costs payable under the program. *Standardized definitions, accounting, statistics, and reporting practices which are widely accepted in the hospital and related fields are followed. Changes in these practices and systems will not be required in order to determine costs payable under the principles of reimbursement.* Essentially the methods of determining costs payable under title XVIII involve making use of data available from the institution's basis accounts, as usually maintained, to arrive at equitable and proper payment for services to beneficiaries. Emphasis added.

In addition 42 CFR 405.453 provides that "The cost data submitted *must* be based on the accrual basis of accounting which is recognized as the *most accurate basis for determining costs.*" Emphasis added.

In short, these regulations provide that:

- widely accepted accounting practices are followed;
- no changes in these practices will be required in order to determine cost; and
- the accrual basis of accounting is the most accurate basis for determining cost.

This language is much stronger than that in *Thor* which, as indicated above, merely provided in part that the consistent application of GAAP would *ordinarily* be regarded as clearly reflecting income unless the Commissioner decided otherwise. Moreover, the Medicare regulations in question do not appear to provide the kind of authority for the Administrator to reject the use of GAAP to determine actual cost that the Supreme Court found in *Thor*. In fact, they appear to go beyond *Thor* in providing not merely a presumption but an actual requirement that determination of costs conform to generally accepted accounting principles. Indeed, the Board believes that these regulations taken together go far beyond requiring GAAP for mere recordkeeping but appear rather to state unequivocally that *cost* shall be determined according to GAAP.

In emphasizing the Supreme Court's analysis of the *role* of GAAP in the income tax system and applying that to Medicare cost reimbursement, the Administrator in effect omitted an analysis of the actual content and wording of the Medicare regulations—an analysis which the Supreme Court had performed in *Thor*. The only law relied on by the Administrator—in addition to the manual provisions at issue—is that part of Section 1861(v)(1)(A) of the Social Security Act which prohibits cross-subsidization.

Essentially, the principle of cross-subsidization assumes that the "cost" of a service has already been determined and merely prohibits allocating or attributing that cost to the wrong subset of patients. The same statute that prohibited cross-subsidization provided that the reasonable cost of any service was the cost actually incurred excluding unnecessary costs. The statute also said that in prescribing regulations

on payment, the Secretary had to consider among other factors the principles generally applied by national organizations in computing the amount of payment. This statute was implemented through many regulations, but the chief ones of concern to this decision are 42 CFR 405.451, 42 CFR 405.406 and 42 CFR 405.453.

While 42 CFR 405.406 and 42 CFR 405.453 appear to address the process of determining actual cost, 42 CFR 405.451 is a substantive limitation on the reimbursement of actual cost. It provides that all payments to providers of services must be based on the reasonable cost of services and related to the care of beneficiaries. Reasonable cost includes all necessary and proper costs. These regulations, at least on their face, would appear to indicate that the actual cost of an item or service would be determined under 42 CFR 405.406 and 405.453 while the allowability of the cost would be determined under 42 CFR 405.451. The Administrator, however, does not address this distinction directly. He states, "The statutory prohibition against cross-subsidization requires that costs recognized in one year, but attributable to health services rendered over a number of years, be amortized and reimbursed during these years when Medicare beneficiaries use these services." He then uses the issue addressed in *Research Medical Center v. Schweiker*, U.S. Court of Appeals, Eighth Circuit, No. 81-2364, Aug. 9, 1982, CCH para. 32,107 to illustrate this interpretation of cross-subsidization and quotes the Court in that case to the effect that "The capitalization requirement of Sec. 206 of the Provider Reimbursement Manual attempts to implement the statutory requirement that Medicare costs should not be borne by non-Medicare

patients." *Baptist Hospital Group*, CCH para. 38,308 at p. 21,690.

What the Administrator is in effect doing is saying that 42 CFR 405.451, pertaining to costs related to the care of beneficiaries and cross-subsidization, encompasses both a substantive element (i.e., is the item an operating table or a television set?) and a timing element (i.e., to what year does the service apply?). We do not agree with this analysis. Timing must be determined in the context of 42 CFR 405.406, i.e., standardized methods of accounting for those costs and 42 CFR 405.453, i.e., expenses are reported in the period in which they are incurred, regardless of when they are paid. Any other interpretation would conflict directly with the plain language of 42 CFR 405.406. In his decision, the Administrator does not address this issue directly.

The problem of the role of GAAP, however, is not always perceived as just an accounting or timing problem. For instance, in the *Florida Patient Compensation Fund cases* (PRRB Case Nos. 89-D32 and 89-D33), the Board majority believed that there was a substantive problem under 42 CFR 405.451 and that a FASB statement could not make allowable a cost, (assessments for incurred but not reported claims (IBNR)), which was not a necessary cost under 42 CFR 405.451—one for which no statutory obligation had as yet arisen. In addition, longstanding manual provisions provided for reimbursement of actuarially unsound self-insurance on a paid claims basis. Thus, in addition to a lack of a statutory basis for collecting IBNR assessments, the majority also looked to the fact that the statutory scheme was to levy and collect on the basis of known claims, with

the state totally lacking the authority to collect otherwise. The majority concluded that under these circumstances the reimbursement treatment should be similar to that of the manual provisions for unsoundly funded self-insurance—on the reimbursement of claims. The dissent believed that FASB 5, which provided for the accrual for contingent liabilities, should apply. The point is not to reargue *Florida* here but to distinguish *Florida* from the case in contention here—which is a conflict between the application of GAAP and a position derived from policy considerations borrowed from *Thor*, a questionable interpretation of cross-subsidization, and some notion of economic reality chosen by the Intermediary and the Administrator.

Indeed, economic reality is the third principle relied on by the Administrator. The Administrator argues that economic realities demonstrate the superiority of amortizing the loss on defeasance rather than allowing the full cost in the year of refinancing as set forth in APB No. 26. The problem with this approach is that while beguiling (who would want to be caught espousing economic unreality?!) it is not a principle embodied in any regulation nor is it required by statute. The governing statute did not say that actual cost would reflect economic reality, and nowhere does the Secretary define economic reality; not in regulation, manual provision, intermediary letter, or any other policy publication.

Further, HCFA has consistently rejected the concept of economic reality argued by providers in cases regarding recapture of depreciation. In both the old and amended versions of the regulation providing for recapture of depreciation, HCFA has adopted a pol-

icy treatment which exactly coincides with that of GAAP. The Administrator rejected the economic reality of reimbursable wear and tear on depreciable assets. The Administrator also rejected the fact that, as an economic reality resulting from the law of supply and demand, a gain on sale of an asset could be completely unrelated to the accumulated depreciation and the actual physical wear and tear on the asset. Thus, the Administrator himself is inconsistent in his acceptance of and approach to the concept of economic reality.

It is clear then that if, in the absence of any defining regulation, a concept of economic reality was used to measure costs, the result would be reimbursement policy schizophrenia, with each provider and intermediary applying their own personal concept of economic reality. The wisdom of adopting some common measurement of costs such as GAAP (which the Secretary appears to have done in 42 CFR 405.406) is thus self- evident. The principles of GAAP are carefully defined and are thus less open to interpretation than an undefined concept of economic reality.

Indeed, if the Administrator wishes to discuss and apply sound policy, it is preferable to have Medicare reimbursement principles based on a consistent, uniform standardized method of accounting, even if that method, GAAP, was historically developed to assure uniform financial reporting. Perhaps the best policy would have been for the Secretary to use GAAP as the basis for measuring costs but to have clearly retained through regulation, as the IRS did in *Thor*, the authority to reject GAAP through manual provisions or other policy pronouncements. We acknowledge that the Secretary can and may have provided

for specific exceptions to GAAP through regulation. He also could have given himself the authority to provide for exceptions to GAAP through manual provisions and other policy pronouncements. However, the Secretary never did the latter.

Case law on this subject is frustrating. Different courts have held for providers and the government, but the Board believes that the decisions to date have not clearly defined the crucial issue. They have not clearly distinguished between the test for allowability of a cost and how the cost should be computed. The test for allowability is provided by 42 CFR 405.451 —the cost must be necessary and proper and related to patient care. On the other hand, the test for determination of the amount of cost is governed by 42 CFR 405.406 and 453. In this case there is no dispute that the cost is allowable under 42 CFR 405.451. However, the Board holds that the *amount* of the cost should be computed in accordance with 42 CFR 405.406 and 453.

In the Board's previous decisions in *Baptist* and in *Mercy*, the Board adopted the analytic approach set forth in *Charlotte Memorial Hospital and Medical Center v. Bowen*, 860 F.2d 595 (4th Cir. 1988). In *Charlotte Memorial* the court addressed the validity of a manual provision prescribing a reimbursement treatment of unfunded deferred compensation plans contrary to the accounting treatment in GAAP. The court clearly stated that it was not deciding the proposition whether the Secretary, in the absence of an enabling regulation, was authorized to prescribe regulatory interpretations that conflict with GAAP. Nevertheless, the court opined that the Secretary, in doing so, would be at the very limit of his authority.

According to the court, such interpretations would be subject to greater scrutiny than interpretations which are consistent with GAAP, because the Secretary does not have to comply with the Administrative Procedure Act when prescribing regulatory interpretations such as those found in HIM 15, the manual provisions. In *Charlotte Memorial* the focus of the scrutiny was,

> whether, with respect to the type of medical cost at issue, the departure from GAAP "do not accurately reflect the cost of patient care, as opposed to the cost of running a business", *Villa View*, 720 F2d at n. 18, *Charlotte Memorial*, p. 18, 194.

The Board no longer relies on *Charlotte Memorial* and instead adopts the test set forth above based in part on its understanding of the analytical approach in *Thor* and its belief that it is the correct legal conclusion. Thus, with regard to any type of medical cost at issue, the first step is to determine actual cost as provided by 42 CFR 405.406 and 453. The focus of scrutiny then becomes whether the cost is necessary and proper and related to patient care as required by 42 CFR 405.451.

In conclusion, the Provider's use of GAAP in reporting a loss on defeasance is correct. The Board holds that the loss is allowable under 42 CFR 405.451 and conforms to the requirements found in 42 CFR 405.406 and 42 CFR 405.453 that actual cost be determined using GAAP.

Issue No. 2—Investment Income Offset

The Board finds that the Provider's interest payment account of the DSF qualifies as funded depreciation under 42 CFR 405.419(6)(2)(iii) and PRM section 226. Thus, the investment income earned by this account does not have to be offset against the Provider's allowable interest expense.

In *General Hospital of Everett*, Decision 88-D14, the Board held that a single Debt Service Found [*sic*] (used to pay interest and principal) met the requirements of a funded depreciation account. In this case there were two accounts which constituted the Debt Service Fund—one for interest and the other for principal. The Board finds this a difference in form, and not substance. The interest account is so closely related to the borrowing that the Board deems it to be a purpose for which funded depreciation monies can be properly used. However, the Board would not extend that reasoning to the maintenance and insurance accounts required by the bond indenture.

DECISION:

Issue No. 1—Loss on Bond Advance Refunding

The Intermediary's adjustment is reversed. The loss on the advance refunding of the 1972 and 1982 bonds is allowed in full in FY 85.

Issue No. 2—Investment Income Offset

The Intermediary's adjustment is reversed. The interest expense account of the DSF is funded depreciation, and the investment income earned by this account does not have to be offset against the Provider's allowable interest expense.

Board Members Participating:

Elise D. Smith
Keith E. Braganza
Sally A. Kirkpatrick

FOR THE BOARD:

AUG 16 1990

/s/ Elise D. Smith
ELISE D. SMITH
Chairman

APPENDIX F

Section 233 of the Secretary's Provider Reimbursement Manual provides as follows:

233. ADVANCE REFUNDING OF DEBT

233.1 *General.*—Advance refunding is a refinancing technique which enables a provider to replace existing debt prior to its scheduled maturity with new debt. This section does not apply to a recall of debt before scheduled maturity without the issuance of new debt. (See § 215, Recall of Debt Before Maturity.) Advance refunding is done for a variety of reasons including achieving a lower interest rate, improving cash flow, removing restrictive covenants, and increasing borrowing capacity. Sections 233.1-233.5 are effective for all refundings initiated on or after July 1, 1983. For purposes of this section, the term "initiated" means either (1) an action taken by the provider which reflects a clear intention to effect the advance refunding (e.g., board resolution empowering the management to proceed with the advance refunding, engagement of an underwriter, application to the debt-issuing authority, etc.), or (2) an official action by the debt-issuing authority reflecting a clear intention to effect the advance refunding.

233.2 *Definitions.*—For purposes of this section the following definitions apply:

Refunding Debt.—New debt issued to provide funds to replace the refunded debt immediately or at a specified future date(s).

Refunded Debt.—Debt for which payment immediately or at a specified future date(s) has been provided by the issuance of refunding debt.

Advance Refunding.—A transaction in which refunding debt is issued to replace the refunded debt immediately or at a specified future date(s).

Defeasance Provision.—A provision in the refunded debt instrument that provides the terms by which the debt may be legally satisfied and the related lien (if any) released without the debt necessarily being retired.

Defeasance.—Legal satisfaction of debt under the terms of a defeasance provision.

233.3 *Allowable Costs.*—When a provider defeases or repurchases debt incurred for necessary patient care through an advance refunding, the revenues and expenses associated with the advance refunding are treated as follows:

A. Debt issue costs on the refunding debt must be amortized over the life of the refunding debt from the date the debt is incurred to scheduled maturity of the debt. (See §§ 204, 206, 210, and 212.1.)

B. Debt cancellation costs on the refunded debt are allowable as indicated below:

1. Redemption expenses and any other miscellaneous expenses (legal fees, initial trustee fees, feasibility studies, stamp fees, printing, etc.) are allowed as paid or accrued (subject to § 2305);

2. Annual authority and trustee fees are allowed as paid or accrued (subject to § 2305);

3. Call premiums or penalties are allowable in the period(s) the holders of the refunded debt receive the principal payment. Call premiums or penalties of serial bonds should be prorated over the scheduled

maturity or recall dates on the basis of the proportionate principal repayments at each date.

C. Unamortized discounts or premiums (reduction of debt cancellation costs) and debt issue costs of the refunded debt must be amortized over the period from the issue date of the refunding debt to the date the holders of the refunded debt will receive the principal payment (appropriately prorated in the case of serial bonds as in B. above).

D. Interest expense on the refunded debt is allowable on an annual basis as paid or accrued, whether by the provider or by a trust. (See § 2305ff.) Similarly, interest expense on the refunding debt is allowable as paid or accrued. The amortized portion of discounts or premiums on the refunding debt is an adjustment to allowable interest expense in accordance with §§ 212.1 or 214, respectively. The interest income derived from the investment of the proceeds of the refunding debt must be used to offset interest expense in accordance with § 202.2, whether this interest income is earned by the provider directly or through a trust.

The effect of the above treatment is to implicitly recognize any gain or loss incurred as the result of an advance refunding over the period from the date the refunding debt is issued to the date the holders of the refunded debt receive the principal payment, rather than immediately. The individual expense elements are the only costs which can be reimbursed in accordance with the above policy.

233.4 *Limitation on Recognition of Costs.*—As with all costs incurred for funds borrowed, the costs associated with an advance refunding must meet the

necessary and proper tests of §§ 202.2 and 202.3, respectively, as well as the reasonable cost provisions of § 2100ff. In addition, sinking funds available for liquidation of the refunded debt must be considered in a determination of necessary borrowing through advance refunding. On occasion a provider may borrow more than the amount required to advance refund the existing debt. If the additional borrowing is for the acquisition of depreciable assets, existing funded depreciation must be taken into account in determining the necessity of the excess borrowing. Generally, the total net aggregate allowable costs (as described in § 233.3) incurred for all cost reporting periods related to the advance refunding cannot exceed the total net aggregate costs that would have been allowable had the advance refunding not occurred. However, in evaluating the necessity, propriety and prudency of an advance refunding, consideration may be given to factors such as cash flow needs or the necessity to remove a restrictive covenant that prevents the provider from borrowing additional funds for an appropriate purpose.

If the provider incurs excess aggregate costs, as described above, the excess costs will be allowable only where the provider can demonstrate to the satisfaction of the intermediary that compelling factors (such as those mentioned above) necessitated the advance refunding. In cases where the provider cannot make such a satisfactory demonstration, the excess costs are unallowable, and the provider's reimbursement would be limited annually to the costs it would have incurred if the old bonds had not been refunded.

233.5 *Treatment of Items for Equity Capital Purposes.*—All debts, and proceeds of those debts, asso-

ciated with advance refunding incurred for necessary patient care are includable in the determination of equity capital in accordance with Chapter 12. However, if interest expense is disallowed under the limitation expressed in § 233.4, the debt (or unreasonable portion thereof) associated with the disallowed interest expense, as well as the related assets, must be excluded in the determination of equity capital.

☆ U. S. GOVERNMENT PRINTING OFFICE: 1984 501157 86102